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81-746

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1981
No. _____

CITY OF AKRON,
Petitioner,

-vs-

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

ROBERT D. PRITT
Director of Law
City of Akron
166 South High Street
Akron, OH 44308
216-375-2031

Attorney For Petitioner

QUESTIONS PRESENTED

1. Whether the state's interest in maternal health and wellbeing is such that it may regulate abortion in a reasonable manner which is not unduly burdensome, even during the first trimester of pregnancy.

2. Whether a child under the age of fifteen years can be required to obtain the consent of one parent or her legal guardian or a court order authorizing the minor to consent to an abortion.

3. Whether the state can require the physician personally to inform the woman of facts relating to her pregnancy, the abortion procedure, fetal development, and agencies available to assist her.

4. Whether the state can require the physician personally to counsel the patient with respect to the risks and technique of the abortion prior to performing the abortion.

5. Whether the state can require a waiting period of twenty-four hours between the signing of an informed-consent form and the performance of an abortion.

6. Whether the term "humane" as it relates to the disposal of fetuses in Section 1870.16 is void for vagueness, and if so, whether the term is severable from the balance of the section in accordance with City Council's express intent that the provision be severable.

PARTIES

Petitioner, the City of Akron, was Defendant below along with John Ballard, Mayor; Dr. C. William Keck, Director of Public Health; and Peter Oldham, Prosecutor. Co-Defendants in the trial court were Dr. Francois Seguin and Mrs. Kathleen Black who were permitted to intervene "in their individual capacity as parents of unmarried daughters of child-bearing age" and who were permitted to appear as amici curiae on all issues in the case. The Respondents in this litigation are Akron Center for Reproductive Health, Inc.; Akron Women's Clinic, Inc.; Womencare, Inc.; and Dr. Bliss, a physician who had worked in one of the abortion clinics and who claimed to represent the rights of clinic patients who desired abortions.

TABLE OF CONTENTS

	Page
Questions Presented	i
Parties	ii
Table of Contents	iii
Table of Authorities	vi
Opinions Below	viii
Jurisdiction	viii
Statutory Provisions	ix
Statement of the Case	1
Reasons for Granting the Writ	5
I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS IN THAT THE APPELLATE COURT (A) FAILED TO DETERMINE WHETHER THE REGULATION WAS "UNDULY BURDENSOME," AND (B) PROHIBITED ALL DIRECT FIRST-TRIMESTER REGULATION.	5
A. The Appellate Court failed to determine whether the regulation was "unduly burdensome."	5
B. The Court of Appeals erred in prohibiting all direct regulation of first-trimester abortions.	8
II. THE RULING BELOW CONFLICTS WITH PRINCIPLES ENUNCIATED IN	

TABLE OF CONTENTS (CONTINUED)

Page

PRIOR DECISIONS OF THIS COURT AS TO THE FACIAL CONSTITUTIONALITY OF REQUIRING PARENTAL OR JUDICIAL CONSENT TO AN IMMATURE, UNEMANCIPATED MINOR'S ABORTION. 11

III. THE COURTS BELOW ERRED IN RULING THAT SECTION 1870.06(B), WHICH ENSURES THAT THE CONSENT FOR AN ABORTION IS TRULY INFORMED CONSENT, WAS UNCONSTITUTIONAL. 15

A. The information required to be provided by the attending physician in accordance with Section 1870.06(B) is accurate and is not unduly burdensome on a pregnant woman's right to an abortion. 15

B. Even if parts of Section 1870.06(b) were unconstitutional, the courts below failed to sever such subsections in accordance with clear legislative intent. 17

IV. THE COURT OF APPEALS FAILED TO RECOGNIZE THE STATE'S LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING PHYSICIAN-PATIENT COUNSELING PRIOR TO THE PERFORMANCE OF AN ABORTION. 22

V. THE COURT OF APPEALS FAILED TO RECOGNIZE THE STATE'S LEGITIMATE INTEREST IN

Page

PROTECTING THE WOMAN'S HEALTH BY REQUIRING A TWENTY-FOUR-HOUR WAITING PERIOD BETWEEN THE SIGNING OF AN INFORMED-CONSENT FORM AND THE PERFORMANCE OF AN ABORTION. 26

VI. THE TERM "HUMANE" AS USED IN SECTION 1870.16 IS NOT UNCONSTITUTIONALLY VAGUE, AND EVEN IF IT WERE, IT SHOULD HAVE BEEN SEVERED FROM THE BALANCE OF THE SECTION IN ACCORDANCE WITH THE LEGISLATIVE INTENT. 28

Conclusion 31

TABLE OF AUTHORITIES

	Page
Akron v. Scalera, 135 Ohio St. 65, 19 N.E. 2d 279 (1939)	14
Bellotti v. Baird, 428 U.S. 132 (1976)	7, 8, 14, 15, 19, 27, 28
Bellotti v. Baird, 443 U.S. 622 (1979)	10, 13, 24
Buckley v. Valeo, 424 U.S. 1 (1976)	21
Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932)	21, 30
Colautti v. Franklin, 439 U.S. 379 (1979)	11, 24
Connecticut v. Menillo, 423 U.S. 9 (1975)	8, 9, 23
Franklin v. Fitzpatrick, 428 U.S. 901 (1976)	8, 9, 19, 29
Griswold v. Connecticut, 381 U.S. 479 (1965)	23
Harris v. McRae, 448 U.S. 297 (1980)	8, 10
H. L. v. Matheson, 450 U.S. ____, 67 L. Ed. 2d 388 (1981)	8, 9, 14, 15, 18, 25, 27, 28
Lies v. Cleveland Ry. Co., 101 Ohio St. 162, 128 N.E. 73 (1920)	14
Maher v. Roe, 432 U.S. 464 (1977)	7, 8, 16, 18, 19
Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La. 1980)	19

TABLE OF AUTHORITIES (CONTINUED)

Page

Planned Parenthood v. Ashcroft, 483 F. Supp. 679, (W.D. Mo. 1980) r'vsd on other grounds, Nos. 80-1130 and 80-1530 (8th Cir. July 8, 1981) 24

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 6, 7, 8, 9, 11, 12, 19, 24, 27, 28

Planned Parenthood Assn. v. Fitzpatrick, 401 F. Supp. 554 (1975), aff'd Franklin v. Fitzpatrick, 428 U.S. 901 (1976) 19, 29, 30

Roe v. Wade, 410 U.S. 113 (1973) 5, 6, 7, 11, 23, 24

Thone v. Womans Services, P.C., ____U.S. ____, 69 L. Ed. 2d 414 (1981) 8, 9, 14, 15, 19, 25, 27

Whalen v. Roe, 429 U.S. 589 (1977) 7

Women's Community Health Center v. Cohen, 477 F. Supp. 542 (D. Me. 1979) 20

Wynn v. Scott, 449 F. Supp. 1302 (N.D. Ill. 1978) 21

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit, rendered on June 12, 1981, has been reported as Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F. 2d 1198 (1981). The opinion of the United States District Court for the Northern District of Ohio, Eastern Division, rendered on August 22, 1979, has been reported as Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979).

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was entered on June 12, 1981. A petition for rehearing was filed with the Court of Appeals by the Petitioners, the Respondents, and the Defendant-Intervenors. The Court of Appeals denied all parties' petitions for rehearing. The Defendant-Intervenors' petition for rehearing was denied on July 22, 1981. This petition for certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked under 28 U.S.C. Section 1254(1).

STATUTORY PROVISIONS INVOLVED

United States Constitution, Amendment XIV, Section 1

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any state deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Ohio Constitution Art. XVIII, Section 3

Municipalities shall have authority to exercise all powers of local self-government and to adopt and enforce within their limits such local police, sanitary and other similar regulations, as are not in conflict with general laws.

Ohio Revised Code Chapter 2151

Ohio Rules of Juvenile Procedure

3 Ohio Administrative Code 3701-47-05

(A) The fetus shall be disposed of in a humane manner.

(B) No person shall experiment upon or sell the product of human conception which is aborted. Experiment does not include autopsies pursuant to sections 313.13 and 2108.50 of the Revised Code.

Akron Ordinance No. 160-1978

STATEMENT OF THE CASE

Ordinance No. 160-1978 was enacted by the Akron, Ohio, City Council on February 28, 1978, in order to provide its citizens with the highest standard of health care. The ordinance, which is set forth in the Appendix, amended and supplemented Chapter 1870, entitled "Regulation of Abortions," of the Codified Ordinances of The City of Akron.

In order to promote the health and safety of women seeking abortions, the City Council enacted the ordinance which sets forth a number of requirements relating to the performance of abortions. One of the requirements, here in controversy, is that a woman prior to performance of the abortion give an informed consent after consultation with her physician. Section 1870.06(B) provides that "[i]n order to insure that the consent for an abortion is truly informed consent . . . ," the attending physician must inform every abortion patient of several enumerated factors relating to a woman's condition of pregnancy and to the unborn child.

Section 1870.06(C) requires that the attending physician provide certain information to the woman regarding the risks associated with her pregnancy and the abortion technique to be employed as well as a general description of the medical instructions to be followed subsequent to the abortion. In addition, any other information which in the physician's judgment is relevant to her decision to have an abortion or

carry the pregnancy to term may be given. The testimony at trial by physicians working for local abortion clinics established that the physicians themselves neither personally consult nor counsel patients prior to an abortion. (Joint App. p. 544)[1]. Rather, non-physician counselors provide such services to a woman prior to her abortion. Several physicians testified at trial that proper medical practice required that a physician counsel the woman. (Joint App. pp. 184, 661, 723-724).

Section 1870.07 of the ordinance requires that there be a twenty-four-hour delay between the time a woman signs the consent form required by Section 1870.06 and the abortion procedure. This section is modified by a section which waives the twenty-four-hour delay in the case of a medical emergency which poses an immediate threat and grave risk to the life or physical health of the pregnant woman. The District Court found that this regulation did not unduly burden the woman's decision and that it furthered the important state interest of insuring "that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation." 479 F. Supp. at 1204.

Section 1870.05(B) provides that the consent of

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[1]All citations to the record below are to the Joint Appendix filed by counsel for the clinics, Dr. Bliss, the parents, and the City of Akron with the Court of Appeals for the Sixth Circuit.

one of her parents or her legal guardian must be obtained prior to an abortion upon a pregnant girl under the age of fifteen years, or, in the alternative, a court may provide consent where the parent or guardian is unavailable or refuses consent. State law provides the procedure to be followed in such a judicial proceeding.

Plaintiffs alleged jurisdiction in the District Court under the First and Fourteenth Amendments to the United States Constitution, 28 U.S.C. Section 1331, 28 U.S.C. Sections 1343(3) and 1343(4), 42 U.S.C. Section 1983, and 28 U.S.C. Sections 2201 and 2202.

On April 19, 1978, an action challenging the facial validity of Ordinance No. 160-1978 was instituted. The ordinance was to have become effective May 1, 1978, but a preliminary injunction restraining its enforcement was entered on April 27, 1978, by the United States District Court for the Northern District of Ohio, the Honorable Leroy J. Contie, Jr., presiding. A trial on the merits was held September 5-21, 1978. A final decision on the merits was rendered on August 22, 1979, holding Sections 1870.05, 1870.06(B), 1870.09, and 1870.16 of the ordinance unconstitutional and permanently enjoining the enforcement of those provisions.

On appeal, the United States Court of Appeals for the Sixth Circuit affirmed in part and reversed in part the judgment of the District Court. The Court

of Appeals opinion, issued June 12, 1981, held Sections 1870.05(B), 1870.06(B), 1870.06(C), 1870.07, and 1870.16 unconstitutional (the District Court's finding that Section 1870.09 was unconstitutional was not appealed).

The Court of Appeals denied motions for rehearing timely filed by the parties, and this petition for writ of certiorari followed.

REASONS FOR GRANTING THE WRIT

I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS IN THAT THE APPELLATE COURT (A) FAILED TO DETERMINE WHETHER THE REGULATION WAS "UNDULY BURDENSOME," AND (B) PROHIBITED ALL DIRECT FIRST-TRIMESTER REGULATION.

A. The Appellate Court failed to determine whether the regulation was "unduly burdensome."

Following this Court's decision of Roe v. Wade, 410 U.S. 113, 163 (1973), in which it was stated that the "state's important and legitimate interest in the health of the mother" became compelling at the end of the first trimester of pregnancy, both State and District Courts have periodically held any regulation of first-trimester abortions to be impermissible.[2]

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[2]As shown by the Court of Appeals holding that "if a regulation resulted in a legally significant impact or consequence on a first-trimester abortion decision, it is invalid." 651 F. 2d at 1204.

Subsequent to Roe v. Wade, however, this Court has made clear that the states have the right to regulate abortions performed during the first three months of pregnancy so long as such regulation does not "unduly burden" a woman's constitutionally-protected right to have an abortion.

This permitted regulation of first-trimester abortions first unfolded in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), wherein this Court upheld a state statute requiring the informed written consent of a woman, in the first trimester of pregnancy, and requiring certain recordkeeping and reporting by those providing the abortion. In its discussion, this Court noted that:

> [T] he state may not restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy . . . [However] the imposition by §3(2) of such a requirement (prior written consent) for termination of pregnancy even during the first stage, in our view, is not in itself an unconstitutional requirement. (Emphasis added) 428 U.S. at 66-7.

Thus not all regulation of first-trimester abortions impermissibly interferes with a woman's protected decision to have an abortion, and the questioned regulation need not always serve a compelling state interest in order to be constitutional. This is shown by this Court's statement in Danforth that the record-keeping requirement:

. . . if not abused or overdone, can be useful to the state's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment. (Emphasis added) 428 U.S. at 81.

It is apparent that a lesser standard of review was utilized by this Court in evaluating the constitutionality of the regulation.

Interpreting the standard to be applied in determining whether or not a regulation was valid, this Court, in Bellotti v. Baird, (Bellotti I), 428 U.S. 132, 147 (1976), noted that in Danforth, it had been:

. . . held that a requirement of written consent on the part of a pregnant adult is not unconstitutional unless it unduly burdens the right to seek an abortion." (Emphasis added.)

The unduly burdensome standard of review enunciated by this Court in Danforth and Bellotti I was said, in Maher v. Roe, 432 U.S. 464, 473 (1977), to balance the woman's interest against the nature of the state's interference in exercising that right. In Maher, the Court noted that:

Whalen [v. Roe, 429 U.S. 589 (1977)], makes clear, the right in Roe v. Wade can be understood only by considering both the woman's interest and the nature of the State's interference with it. 432 U.S. at 473.

Granted, an abortion regulation must not unduly burden a woman's constitutionally-protected right to have an abortion. However, the Court of Appeals refused to even make such an inquiry of the Akron

ordinance. Connecticut v. Menillo, 423 U. S. 9 (1975); Danforth, supra; Bellotti I, supra; Franklin v. Fitzpatrick, 428 U.S. 901 (1976); Maher, supra; Harris v. McRae, 448 U.S. 297 (1980); and H. L. v. Matheson, 450 U.S. ____, 67 L. Ed. 2d 388 (1981).

B. The Court of Appeals erred in prohibiting all direct regulation of first-trimester abortions.

In applying a two-tier analysis to the Akron abortion ordinance, the Court of Appeals incorrectly interpreted prior decisions of this Court, especially in light of the recent decisions of Matheson, supra, and Thone v. Womens Services, P.C., ___U. S.___, 69 L. Ed. 2d 414 (1981), and in effect held all first-trimester regulation to be impermissible.

Initially, the Appellate Court looked to "the nature of the particular regulatory provision," inquiring as to whether or not the regulation had a " 'legally significant impact or consequence' on the right of a pregnant woman, in consultation with a physician, to choose to terminate her pregnancy." Accordingly, if there was no legally significant impact or consequence, no constitutional issue was raised. Where the regulation resulted in a legally significant impact or consequence, the Court further required that the "regulatory provision serve a legitimate and compelling state interest." But, only if a compelling state interest were found would it further inquire as to whether the regulation imposed

an "undue burden" on the abortion decision. 651 F. 2d at 1204.

This "two-step analysis" required by the Court of Appeals also provided that first trimester regulations are per se invalid if they result in a legally significant impact or consequence, holding as a matter of law that the state has no compelling interest during the first trimester. 651 F. 2d at 1204. Such a standard of review goes far beyond the prior decisions of this Court allowing the direct regulation of first-trimester abortions. Menillo, supra; Danforth, supra; Franklin, supra; Matheson, supra; Thone, supra.

Recently, in Matheson, this Court upheld a requirement of prior parental notice where a minor seeks an abortion. The Court recognized that:

> As applied to immature and dependent minors, the statute plainly serves the important considerations of family integrity and protecting adolescents which we identified in Bellotti II . . . The Utah statute is reasonably calculated to protect minors in appellant's class by enhancing the potential for parental consultation concerning a decision that has potentially traumatic and permanent consequences. (Emphasis added). 450 U.S. ___, 67 L. Ed. 2d at 399.

In so holding, this Court apparently did not apply a compelling state interest test. But even if such a test must be met, it is implied that the state has such an interest in this and all other first-trimester abortion regulations which have been held constitutional by this Court.

Of key importance is the fact that the regulation was one imposed on first-trimester abortion decisions and one which resulted in a legally significant impact, and, yet, the regulation was constitutionally permissible. Unquestionably, a statute requiring parental notification of a minor's decision to have an abortion results in a legally significant impact on the minor's constitutionally protected decision. In recognizing the impact such a regulation has, this Court stated:

> That the requirement of notice to parents may inhibit some minors from seeking abortions is not a valid basis to void the statute as applied to appellant and the class properly before us. The Constitution does not compel a state to fine-tune its statutes so as to encourage or facilitate abortions. To the contrary, state action "encouraging childbirth except in the most urgent circumstances" is "rationally related to the legitimate governmental objective of protecting potential life." Harris v. McRae, supra. 448 U.S., at 325.

The regulation, however, is not unconstitutional merely because it has a legally significant impact on the first-trimester abortion decision.

In determining the constitutionality of an abortion regulation, this Court has consistently required only that the regulation not be unduly burdensome. Bellotti v. Baird, (Bellotti II), 443 U.S. 622, 640 (1979), the mere fact that the regulation pertained to the first trimester of pregnancy did not automatically invalidate the provision.

When viewed in this light, the sections of the Akron ordinance here under review are clearly

constitutional as they do not unduly burden the woman's right to seek an abortion. The Court of Appeals' two-tier analysis conflicts with the standard of review thus far enunciated by this Court in that it prohibits all direct regulation of first-trimester abortions on the basis of there being no compelling interest per se during the first trimester. Regulatory provisions applicable to first-trimester abortion decisions are not unconstitutional simply because they have a legally significant impact on a first-trimester abortion decision. Such a test is merely conclusory and no test at all. In effect, the legal significance of a regulation would hinge on whether its impact is "legally significant." As stated by Judge Kennedy in her dissenting opinion:

> . . . the Supreme Court has never suggested the analysis put forth by the majority. It has sometimes suggested that a compelling state interest is necessary to justify any state regulation of abortion during the first trimester, but that language has always been far broader than required by the facts before it. With the exception of the passage in Colautti, supra, and a part of Planned Parenthood, all of the cases since Roe have suggested that the proper standard is simply whether a regulation that does not effectively prohibit abortions is "unduly burdensome" to the decision whether or not to abort. The Court's decisions are all consistent with that standard. 651 F. 2d at 1215.

II. THE RULING BELOW CONFLICTS WITH PRINCIPLES ENUNCIATED IN PRIOR DECISIONS OF THIS COURT AS TO THE FACIAL CONSTITUTIONALITY OF REQUIRING PARENTAL OR JUDICIAL

CONSENT TO AN IMMATURE, UNEMANCIPATED MINOR'S ABORTION.

The Supreme Court first addressed the issue of requiring a parent's consent to a minor's abortion in Danforth, supra, 428 U.S. at 72-75, in which it was held that a blanket requirement that an unmarried girl obtain parental consent to an abortion was unconstitutional as it imposed an absolute veto power over a minor's decision to have an abortion. As the District Court recognized:

> . . . the court (in Danforth) specifically noted, however, that its holding should not be read as a suggestion that all minors have the capability of giving effective consent to the performance of an abortion. 479 F. Supp. at 1201.

The Akron ordinance under consideration, Section 1870.05(B), is directed at minors unable to give an effective consent and in so regulating it does not provide anyone with an "absolute veto." Section 1870.05(B) provides that the consent of one parent or the legal guardian must be obtained prior to an abortion upon a pregnant minor under the age of fifteen years or, in the alternative, a court may provide consent where the parents or guardian are either unavailable or refuse consent. The applicable procedure to be followed in a juvenile judicial proceeding where a minor is seeking court approval of an abortion is provided by state law under Chapter 2151 of the Ohio Revised Code and the Ohio Rules of Juvenile Procedure. As such provisions were not

constitutionally challenged "as applied" to judicial proceedings in which a minor seeks an abortion, and since the District Court made no finding as to their operation and effect, these provisions cannot form the basis for holding that Section 1870.05(B) is unconstitutional.

When faced with a similar regulation requiring parental consent to a minor's abortion, this Court in Bellotti II expounded upon the constitutionality of such provisions, stating that:

> . . . if the state decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure [22] whereby authorization for the abortion can be obtained . . . n. 22 . . . we discuss the alternative procedure described in the text in terms of judicial proceedings. We do not suggest, however, that a state choosing to require parental consent could not delegate the alternative procedure to a juvenile court or an administrative agency or officer. Indeed, much can be said for employing procedures and a forum less formal than those associated with a court of general jurisdiction. 443 U.S. at 643.

The Akron ordinance provides such an "alternative procedure" whereby authorization for the abortion can be obtained in accordance with the constitutional requirements enunciated by this Court in Bellotti II. Section 1870.05 does not purport to determine either the nature of the judicial alternative or the procedure to be followed in such cases, as state law provides a mandatory procedure to be followed in juvenile proceedings. The City of

Akron is prohibited under the Ohio Constitution from legislating in areas in which the state has enacted general laws. Ohio Const. Art. XVIII, Section 3. Any attempt by the City to so legislate would be a nullity under Ohio law. Lies v. Cleveland Ry. Co., 101 Ohio St. 162, 128 N.E. 73 (1920). Akron v. Scalera, 135 Ohio St. 65, 19 N.E. 2d 279 (1939). As the statutory provisions governing juvenile judicial proceedings were not constitutionally challenged in these proceedings, the Akron ordinances should properly be reviewed in light of a constitutional judicial alternative.

It is not to be assumed that during the course of the juvenile proceedings the Court will not construe the ordinance in a manner consistent with the constitutional requirement of a determination of the minor's ability to make an informed consent. So construed, the regulation is constitutionally permissible. Unless and until the section is challenged by a minor who claims to be mature or emancipated, a holding that Section 1870.05(B) is unconstitutional is improper and premature. In Bellotti I, supra, and in Matheson, supra, this Court refused to strike down legislation on its face without a state court's determination as to construction and application of the laws in question.

Recently, this Court vacated the decision of the Court of Appeals, in Thone, supra, wherein it had held a parental consultation requirement to be

constitutional. In vacating the Court of Appeal's decision in Thone, this Court remanded for reconsideration in light of the recent decision in Matheson, supra.

The Court recognized that:

As in Bellotti I, supra, "we are concerned with a statute directed toward minors, as to whom there are unquestionably greater risks of inability to give an informed consent." Id., at 147. 450 U.S. ——, 67 L. Ed. 2d 399.

Finally, it must be stressed that the parental consent provision here under consideration applies only to minor girls fourteen years of age and under.

III. THE COURTS BELOW ERRED IN RULING THAT SECTION 1870.06(B), WHICH ENSURES THAT THE CONSENT FOR AN ABORTION IS TRULY INFORMED CONSENT, WAS UNCONSTITUTIONAL.

A. The information required to be provided by the attending physician in accordance with Section 1870.06(B) is accurate and is not unduly burdensome on a pregnant woman's right to an abortion.

Section 1870.06(B) provides that an attending physician must inform a woman prior to an abortion of several enumerated factors, including that she is pregnant, the number of weeks elapsed, information regarding fetal development, possible complications, that abortion is a major surgical procedure, and the availability of agencies to assist her. This requirement is designed to protect the woman and ensure that her consent will be truly informed. Such a

provision strikes a reasonable balance between the woman's right of privacy and the state's interest in maternal health and ensuring the informed consent of the patient. Maher, supra, 432 U.S. at 473. It is important that the woman have this information prior to the abortion.

Contrary to the Respondents' allegations in the courts below, nothing in this section denies the physician flexibility, as Section 1870.06(C) expressly permits the physician to:

> . . . provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

Only with such knowledge as that required by Section 1870.06(B) can the pregnant woman make a truly informed decision.

The District Court made no findings of fact regarding the subsections involved. Its decision was simply based upon its ruling that the state cannot "specify what each patient must be told." 479 F. Supp. 1203. The Court improperly stated that "defendants were unable to prove that some of the matters required to be told a patient as facts by Subsection (B) were true." 479 F. Supp. 1203. However, the burden of proof was the Respondents' as to the untruthfulness of any such facts, which they failed to show. The courts below erred in not upholding Section 1870.06(B) in its entirety.

B. Even if parts of Section 1870.06(b) were unconstitutional, the courts below failed to sever such subsections in accordance with clear legislative intent.

Section 1870.06(B) was struck down in its entirety by the District Court notwithstanding that several subsections were found constitutional. Subsections (1), (2), (6), and (7) are doubtless rationally related to a woman's maternal health and do not unduly burden her decision to have an abortion. Such subsections should have been severed from the subsections found to be unconstitutional.

Subsections (1), (2), (6), and (7) provide respectively that prior to the giving of an informed consent, a woman is to be told by her attending physician (1) that she is pregnant, (2) the number of weeks that have elapsed from the probable time of conception, (3) that there are numerous public and private agencies available to her with birth control information and that, upon request, the physician will give her a list of such agencies and the services available, and (4) that there are numerous public and private agencies which are available to assist her during pregnancy and after the birth of her child if she chooses not to have an abortion and that, upon request, the physician will provide her with a list.

Not only are these requirements not unconstitutional, but they contain information necessary for a patient to make an informed decision. Indeed, it is

hard to dispute a regulation which requires a physician to tell a woman prior to an abortion that she is pregnant and the number of weeks that have elapsed since she conceived. It can, likewise, not be doubted that birth control is relevant information to the woman and that such information bears an important relation to the maternal health of the woman. The final regulation is designed not only to encourage childbirth, but also to insure that the woman makes a truly informed decision, and as such, is valid. Matheson, supra. In upholding a state's preference for childbirth, in Maher, supra, this Court stated:

> We think it abundantly clear that a state is not required to show a compelling interest for its policy choice to favor normal childbirth . . . .

An informational requirement, such as that contained in the Akron ordinance, was recently approved in a footnote by this Court in Matheson. The statute under review in that case provided that no abortion could be performed

> . . . unless a "voluntary and written consent" is first obtained by the attending physician from the patient. In order for such a consent to be 'voluntary and informed' the patient must be advised at a minimum about available adoption services, about fetal development, and about foreseeable complications and risks of an abortion." 450 U.S. ____, 67 L. Ed. 2d at 393.

Following the decision in Matheson, this Court

vacated an order, in Thone, supra, which had invalidated a detailed informed consent provision in the Nebraska statute.

Regarding a woman's informed consent, this Court has frequently recognized that:

> The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. Danforth, supra, 428 U.S. at 67; see also, Franklin v. Fitzpatrick, 428 U.S. 901 (1976); Bellotti I, supra; and Maher, supra.

This Court approved an informed consent provision in Franklin v. Fitzpatrick, supra, which affirmed the three-judge District Court's decision in Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (1975). The District Court, in upholding the provision, noted that:

> In that event, while telling a patient that the law requires such advice, the Act does not foreclose the physician from putting this statement in perspective for a given patient by reassurances, or by comparing the risks of other options. Proper counseling, it would appear, could incorporate the information demanded by the state and tailor the comprehensive advice to the individual case. 401 F. Supp. at 588.

In keeping with the concern expressed for the patient's informed consent in Danforth, the District Court, in Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La., 1980), severed unconstitutional sections from constitutional sections of an informed consent requirement. The District Court upheld a regulation requiring that a woman be informed that she is

pregnant; the number of weeks elapsed; the particular risks associated with her pregnancy and the abortion technique to be employed; medical instructions to be followed subsequent to the abortion to insure safe recovery; information as to public and private agencies available and the location of public mental health agencies for post-partum psychological damage.

Similarly, in the case of Women's Community Health Center v. Cohen, 477 F. Supp. 542 (D. Me. 1979), the District Court refused to preliminarily enjoin a statute similar to the Akron ordinance, except for a fetal information requirement, holding that the plaintiffs had failed to show a sufficient likelihood that the consent requirement unduly burdens a woman's abortion decision.

Out of the seven subsections of Section 1870.06(B), four are clearly constitutional and should have been severed from those held unconstitutional. The district court quite liberally applied the severability clause, Section 1870.19, to numerous sections, even severing words and phrases out of sentences, and yet refused to apply severability to Section 1870.06(B) which could have been severed quite easily in accordance with the intent of the framers of Chapter 1870. In failing to sever the subsections, the courts below ignored the clear legislative intent as expressed in Section 1870.19.

The test to determine severability as stated by

the District Court in Wynn v. Scott, 449 F. Supp. 1302, (N.D. Ill. 1978), is: (1) are the sections so intertwined that structurally and logically a constitutional defect in one will taint the remainder; (2) what is the will of the legislature; (3) is the statute a product of impermissible state purpose; that is, does every section, in fact, discourage and frustrate the abortion decision; and (4) is it possible to predict what the legislature would do if part of the act were held unconstitutional?

The subsections are not so intertwined that any defects in subsections 3, 4, and 5 taint the remainder. If severed, 1870.06(B) will be completely comprehensible and will clearly inform a physician of what must be told a woman prior to obtaining her informed consent. The informational requirement aids the patient in making a truly informed decision.

The severability of a section, as enunciated by this Court in Buckley v. Valeo, 424 U.S. 1, 108 (1976) was stated as follows:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law. Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932).

The lower courts found that the unconstitutional sections did not require that the entire ordinance be struck down. 651 F. 2d at 1200. This finding should be applied to the severability of

Section 1870.06(B) and its subsections which, if severed, would require the attending physician to communicate the information in subsections 1, 2, 6, and 7 to the patient. Such a requirement is not unconstitutional. The courts below have failed to effectuate the express legislative intent of the City Council by severing the unconstitutional sections of 1870.06(B).

IV. THE COURT OF APPEALS FAILED TO RECOGNIZE THE STATE'S LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING PHYSICIAN-PATIENT COUNSELING PRIOR TO THE PERFORMANCE OF AN ABORTION.

In order to protect the health and safety of women seeking abortions, the City Council, in Section 1870.06(C), requires that the attending physician inform the pregnant woman:

> . . . of the particular risks associated with her own pregnancy and the abortion technique to be employed, including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery; and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

In reversing the District Court's finding that this section was constitutional, the Court of Appeals stated that "Section 1870.06(C) impinges on the medical judgment of the attending physician . . ." 651 F. 2d at 1207. No finding, however, was made that the section interfered with the woman's right to

decide to have an abortion. The core of the constitutional protection recognized in Roe v. Wade, supra, is the woman's right to have an abortion in consultation with her physician. This constitutional protection does not guarantee "a physician freedom to practice medicine free of state regulation." 479 F. Supp. at 1198. The privacy of Roe v. Wade is not simply a right of personal privacy or a "right to your own body," but the privacy of the relationship between the woman and her physician, just like the privacy of the marital relationship in Griswold v. Connecticut, 381 U.S. 479 (1965).

Section 1870.06(C) was enacted to ensure that the consultation protected in Roe v. Wade actually take place. As stated previously, it is the current practice of Akron abortion clinics not to provide such consultation between physician and patient. 479 F. Supp. at 1204. The necessity for consultation prior to the abortion, however, was undisputed. This section does not interfere with the woman's fundamental right to decide whether to terminate her pregnancy. Rather, it ensures the participation of the attending physician in a vital decision.

The physician-patient relationship is an essential component of the woman's constitutional right to decide to have an abortion, as made clear by the decisions of this Court. Most notably, in Connecticut v. Menillo, 423 U.S. 9 (1975), this Court upheld criminal sanctions imposed against violators

of a state statute which prohibited anyone other than a physician from performing an abortion.

In upholding a provision similar to that contained in the Akron ordinance, the District Court, in Planned Parenthood v. Ashcroft, 483 F. Supp. 679 (W.D. Mo. 1980), r'vsd on other grounds, Nos. 80-1130 and 80-1530 (8th Cir. July 8, 1981), stated that:

> The Supreme Court has emphasized the participation and responsibility of the woman's physician regarding the decision to have an abortion and has noted the legitimacy of the state's interest that she make the decision with full knowledge of its nature and consequences. Planned Parenthood v. Danforth, supra. A requirement that the attending physician personally provide information regarding the abortion decision furthers that interest and is not unconstitutional. Planned Parenthood v. Ashcroft, supra at 28.

The giving of the information contained in Section 1870.06(C) "enhances, rather than restricts, the woman's freedom of choice." (Dissenting opinion), 651 F. 2d 1217. Such information does not confine the physician's discretion, but simply reiterates his common law and ethical duty. This court has repeatedly recognized the importance of the physician-patient relationship to the abortion decision. Roe v. Wade, supra, 410 U.S. at 163, 164; Danforth, supra, 428 U.S. at 61; Bellotti II, supra, 443 U.S. at 641 n. 21, 643. In Colautti v. Franklin, 439 U.S. 379, 387 (1979), this court observed that:

> Roe stressed repeatedly the central role of the physician, both in consulting with the woman about

whether or not to have an abortion, and in determining how any abortion was to be carried out.

Most recently, this Court, in Thone, supra, vacated the Court of Appeals order invalidating a detailed informed consent provision in the Nebraska statute applicable to first-trimester pregnancies and remanded for further consideration in light of Matheson, supra.

In holding Section 1870.06(C) to be constitutional the District Court recognized that by requiring the attending physician to provide such information, the effectuation of the abortion decision was thereby made more expensive. Such an impact, however, did not invalidate the provision. A reasonable balance was struck between the state's interest in the health of its female citizens and the woman's rights. The District Court stated:

> That impact is not so great as to require a compelling state interest to support the requirement that the "counseling" be done by the physician rather than by another individual. Akron's City Council could well have rationally concluded that because of the special relationship between a patient and her physician, such "counseling" should be done by the physician. In so doing, it would be furthering a valid state interest in the health of its female citizens. 479 F. Supp. at 1204.

Section 1870.06(C) of the Akron ordinance does not impermissibly interfere with the physician-patient relationship which is so fundamental to the constitutionally protected right to decide to have an abortion. Rather, it furthers a valid state interest in

the health of its female citizens and assures that the woman's consent will be truly informed.

V. THE COURT OF APPEALS FAILED TO RECOGNIZE THE STATE'S LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING A TWENTY-FOUR-HOUR WAITING PERIOD BETWEEN THE SIGNING OF AN INFORMED-CONSENT FORM AND THE PERFORMANCE OF AN ABORTION.

The imposition of a twenty-four-hour delay between the time a woman signs the informed-consent form and the abortion procedure was found by the District Court not to be unduly burdensome on the woman's decision to have an abortion. 479 F. Supp. at 1204. In reaching this decision, the District Court held that Section 1870.07 furthered the important state interest of insuring "that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation." 479 F. Supp. 1204.

On appeal, the District Court's holding was reversed. The Court of Appeals stated that "since Section 1870.07 causes a legally significant impact or consequence on the abortion decision, it cannot be applied to first-trimester abortions." 651 F.2d at 1208. The Court of Appeals, thus, invalidated this section only because it impacted on decisions to have

an abortion during the first three months of pregnancy. The proper standard of review, as discussed earlier, requires that in considering the regulation the focus be placed on the burden imposed on the woman's decision to have an abortion. Danforth, supra; Bellotti I, and Matheson, supra.

A parental notification requirement was upheld by this Court in Matheson, even though it resulted in a legally significant impact on the minor's constitutionally protected decision to have an abortion during the first trimester of pregnancy. In so holding, this Court recognized "that the requirement of notice to parents may inhibit some minors from seeking abortions." The Court, however, stated that this was not "a valid basis to void the statute," 450 U.S. ____, 67 L. Ed. 2d at 400.

Following the decision in Matheson, this Court vacated the judgment of the Eighth Circuit Court of Appeals in Thone, supra, wherein a forty-eight-hour waiting period had been held unconstitutional. In vacating the judgment, this Court remanded the case to the Court of Appeals for reconsideration in light of its decision in Matheson. It is apparent that a first-trimester regulation is not automatically invalid.

It is important to note that the twenty-four-hour waiting period requirement is inapplicable in the case of a medical emergency which poses an

immediate and grave risk to the life and physical health of the pregnant woman under Section 1870.12. The medical expert testifying for the clinics testified that the waiting period would not create a significant risk to the patient's physical health. (Joint App. p. 82, 94, and 118). The section is thus drawn so as not to impose an undue burden on the patient.

By delaying the effectuation of the abortion decision, a reasonable balance is struck between the state's important interest of ensuring careful consideration of that decision by the woman and the woman's right to decide to have an abortion. The District Court, in accordance with the standard of review enunciated by this Court, found that the regulation did not unduly burden the woman's constitutional rights. In reversing the District Court, the Court of Appeals applied an overly stringent standard of review to the regulation which conflicts with the standard enunciated by this Court. Danforth, supra; Bellotti I, supra; and Matheson, supra.

VI. THE TERM "HUMANE" AS USED IN SECTION 1870.16 IS NOT UNCONSTITUTIONALLY VAGUE, AND EVEN IF IT WERE, IT SHOULD HAVE BEEN SEVERED FROM THE BALANCE OF THE SECTION IN ACCORDANCE WITH THE LEGISLATIVE INTENT.

The courts below found Section 1870.16 to be

unconstitutionally void for vagueness. This was due to the fact that the section which deals with the disposal of the remains required that it be done in a humane and sanitary manner. The District Court found that the word "humane" was void for vagueness. The overall intent of the section is, as was noted in Planned Parenthood Assn. v. Fitzpatrick, 401 F. Supp. 554, 573 (1975), aff'd Franklin v. Fitzpatrick, 428 U.S. 901 (1976), "to preclude the mindless dumping of aborted fetuses on garbage piles." In Fitzpatrick, the three-judge District Court upheld a regulation which provided that the Department of Health make regulations for the humane disposal of remains.

The language used in this section was largely taken from a state regulation which provides that "the fetus shall be disposed of in a humane manner." 3 Ohio Administrative Code 3701-47-05 1979. In light of the intent of Section 1870.16, it is clearly not void for vagueness.

Even if the term "humane" were found to be void for vagueness, the entire section should not have been struck down. By severing the term "humane" and allowing the balance to remain, the District Court would have insured two goals: (1) that potential criminal liability could not be founded on an ordinance which local abortion clinics might have difficulty construing and (2) that the health and safety of the Akron community would be furthered by

providing for the sanitary disposal of the fetus. It can hardly be doubted that the health of the community would be furthered by such a requirement and that such a regulation is reasonably within Akron's power. Planned Parenthood Assn. v. Fitzpatrick, 401 F. Supp. 554 (1975).

In addition, by so severing the section the courts below would have been following the manifest intent of the City Council which had provided in Section 1870.19 that a finding of unconstitutionality of one provision was not to result in the striking of the entire ordinance. Champlin, Supra.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the Sixth Circuit.

Dated October 16, 1981.

Respectfully submitted,

Robt D. Pritt

ROBERT D. PRITT
Director of Law
The City of Akron
304 Municipal Building
Akron, OH 44308-1655
(216) 375-2031

Attorney for Petitioner

Office - Supreme Court, U.S.
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Nos. 81-746 and 81-1172

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners

v.

CITY OF AKRON, *ET AL.*,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

[Counsel Listed on Inside Cover]

Washington, D.C. • THIEL PRESS • (202) 638-4521

Petition for Certiorari in No. 81-746 Filed October 13, 1981
Petition for Certiorari in No. 81-1172 Filed December 19, 1981
Certiorari Granted May 24, 1982

JANET BENSHOOF
SUZANNE M. LYNN
NAN D. HUNTER
American Civil Liberties
Union Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

STEPHAN LANDSMAN
Cleveland-Marshall
College of Law
Cleveland State University
Cleveland, Ohio 44155
(212) 687-2328

Attorneys for Respondents and Cross-Petitioners

ROBERT D. PRITT
Director of Law
City of Akron
166 South High Street
Akron, Ohio 44308-1655
(216) 375-2031

Attorney for Petitioner

TABLE OF CONTENTS

	Page
Docket Entries	1a
Motion of Plaintiff to present affidavit of Plaintiff Dr. Doe in a sealed envelope with Memorandum in Support and an affidavit of Dr. Doe	35a
Sealed Affidavit of Dr. Doe to proceed by pseudonym with deletions	38a
Motion of Plaintiffs to present affidavit of Plaintiff Loe in a sealed envelope with Memorandum in Support and an Affidavit of Linda Loe	42a
Sealed Affidavit of Dr. Doe to proceed by pseudonym with deletions	48a
Sealed Affidavit of Linda Loe to proceed by pseudonym with deletions	51a
Order Denying Motion of Plaintiff to allow Dr. Doe to proceed under such pseudonym	53a
Order Denying Motion of Plaintiff to allow Linda Loe to proceed under such pseudonym	57a
Motion to Reconsider with affidavits of Norma Goldberger and Kathy Gotshall	60a
Order Denying Motion of Plaintiffs to Reconsider	70a
Plaintiffs' Fourth Amended Complaint	71a
Defendants' Answer to Fourth Amended Complaint	82a
Excerpts from Transcripts:	
"B", Dr.	241a
Black, Patricia K.	222a
Bliss, Dr. Robert	215a
Bolitho, Yvonne	148a
Bowen, Dr. Charles V.	119a
Brooks, Reginald K.	171a
"C", Dr.	228a
Crist, Dr. Robert Dale	87a

Transcript Excerpts, continued: Page

Crossman, Fern 216a
David, Henry, Ph.D. 179a
Goldberger, Norma 137a, 223a
Gotshall, Kathleen 112a, 220a
Heald, Dr. Felix P. 128a
Hofmann, Dr. Adele 156a
Hurst, Starlett C. 147a
Kapper, Ray 203a
Katz, Dr. Jay 187a
Keck, Dr. Carl William 209a
Kerenyi, Dr. Thomas 211a
Lucas, Francine 247a
Parker, Marcia M. 168a
Robbins, Dr. Frederick 207a
Schmidt, Dr. Richard T. F. 278a
Segedy, Alan G. 145a
Seguin, Dr. Francois 234a
Shelly, Dr. Mildred 282a
Sim, Dr. Myre 259a
Stipulation of Counsel 197a
Tietze, Dr. Christopher 198a
Wilke, Dr. John C. 276a
Williams, Dr. Jasper 281a

Plaintiffs' Exhibits:

10 Akron Center for Reproductive Health Consent to Abortion Form, admitted at Trial, T. II, 23, 24 ..... 285a

17 Akron Center for Reproductive Health Demographics on Parental Knowledge, December 1977-July 1978, admitted at Trial, T. I, 172, 228 ..... 287a

Plaintiffs' Exhibits, continued: *Page*

24 Akron Women's Clinic Statistics on First 650 Patients, dated May 1977, admitted at Trial, T. II, 148, 195 . . . . . 288a

30 Akron Women's Clinic Information Sheet Regarding Pregnancy, admitted at Trial, T. II, 145 . . . . . 290a

32 Akron Women's Clinic Patient Informed Consent Form, admitted at Trial, T. II, 146, 147 . . . . . 292a

37 WomenCare Patient Informed Consent Form, admitted at Trial, T. III, 34, 35 . . . . . 297a

45 Chapter 3701-47 ("Abortions" of Ohio Administrative Code), definition and section governing counseling, admitted at Trial, T. I, 22 . . . . . 299a

46 Akron City Hospital Abortions—Elective and Therapeutic, admitted at Trial, T. IV, 137, 140 . . 300a

47 Akron General Medical Center Report on Abortions, dated August 25, 1978, covering May 1977-April 1978, admitted at Trial, T. IV, 22, 25 . . . . . 301a

48 Statement by C. William Keck, M.D., M.P.H., to Akron City Council Health & Social Service Committee, dated February 4, 1978, with attached article, admitted at Trial, T. V, 50 . . . . . 304a

50 Statement on Abortion Ordinances by Dr. Charles Bowen, speaking for the Summit County Medical Society, admitted at Trial, T. II, 36, 37 . . . . . 317a

51 Statement by Akron Mayor John S. Ballard, dated March 8, 1978, on his decision to allow Ordinance No. 160-1978 to become law without his signature, admitted at Trial, T. III, 7 . . . . . 320a

Weinberger Deposition, admitted at Trial, T.X., offered p. 237, received, p. 244 [R 171] 322a

Ohio Rev. Code Ann. §§ 2151.03; 2151.04; 2151.05; 2151.23; 2151.33; 2317.54; 2919.12; 3109.4 [Banks-Baldwin 1981] 325a

The following opinions have been omitted in printing this appendix because they appear on the following pages in the appendix to the Printed Petition for Certiorari:

Opinion of the United States District Court, Northern District of Ohio, Eastern Division, at 43a-106a

Order of the United States District Court, Northern District of Ohio, Eastern Division, on Motion for New Trial, at 107a-111a

Opinion of the United States Court of Appeals for the Sixth Circuit, at 1a-42a

DOCKET ENTRIES
Case No. C78-155A

4-19-78

1. *Complaint* (Class action) filed. Summons issued. Four copies of complaint with four copies of summons issued to U.S. Marshal 4-19-78.

2. *Motion* of plaintiff for a TRO filed. Four copies issued to U.S. Marshal 4-19-78.

2A. *Exhibits* to plaintiffs' motion for TRO filed. Four copies issued to U.S. Marshal 4-19-78.

Three Sealed Envelopes bearing return address of Cleveland State University with true name affidavit of Wanda Woe, Dr. Doe and Lori Lee lodged.

3. *Motion* of plaintiff and memorandum in support of certification as a class action filed. Four copies issued to U.S. Marshal 4-19-78.

4. *Motion* of plaintiff to present affidavit of plaintiff Doe in a sealed envelope with memorandum in support and attachments filed. Four copies issued to U.S. Marshal 4-19-78.

5. *Notice of Hearing* on plaintiffs' motion for TRO at 3 p.m. on 4-27-78 filed. Copies (4) issued to U.S. Marshal & copies mailed 4-20-78.

4-20-78

6. *Order* that defendants file response to plaintiffs' motion to certify action as a class action by 5-1-78 at 9 a.m. filed. Contie, J. Four certified copies issued to U.S. Marshal and copies mailed to plaintiffs' counsel 4-20-78.

4-25-78

7. *Notice* of plaintiffs to take deposition of Robert L. Goehler at 9 a.m. on 5-2-78 filed. Copy mailed 4-25-78.

8. *Motion* of plaintiffs to take deposition prior to expiration of thirty days with memorandum in support filed. Copy mailed 4-25-78.

9. *Supplemental Memorandum* in support of plaintiffs' motion for class action certification filed. Copy mailed 4-25-78.

10. *Supplemental Memorandum* in support of plaintiffs' motion for TRO with attachments filed. Copy mailed 4-25-78.

4-26-78

11. *Petition* to intervene of Francois Seguin, M.D. & Patricia K. Black with Memorandum in support and attachments filed.

4-27-78

12. *Memorandum* of defendants in opposition to TRO filed. Copies mailed 4-27-78.

13. *Affidavit* of Kathy Gotshall filed. No service.

14. *Affidavit* of Starlett C. Hurst filed.

15. *Order* denying motion of plaintiffs to retain true name affidavit of plaintiff Dr. Doe, a pseudonym. Further, pltfs. are granted five days from date of this Order to amend their complaint filed. Contie, J. Copies hand delivered 4-27-78.

16. *Minutes* of proceedings filed. Contie, J. Kraemer, r. Heard by the Court 4-27-78. Total trial time: 40 min. TRO hearing.

4-28-78

17. *Order* granting motion of plaintiffs' for TRO. Hearing on application for preliminary injunction is consolidated with trial on merits, & such is scheduled for 5-30-78 at 9 a.m. filed. Contie, J. Copies mailed 4-28-78.

5-2-78

18. *Marshal's Return* re (4) Summons & complaint filed. Served John S. Ballard, 4-21-78, Dr. C. Wm. Keck, Peter Oldham, 4-24-78, and City of Akron, 4-21-78. Fees $36.72.

19. *Letter* from James L. Bickett with letter (copy) attached from Mr. Bickett to Wayne G. Hawley indicating Robert Goehler has 10 cassette tapes of public hearings.

20. *First Amended Complaint* filed. Copies mailed 5-2-78.

21. *Memorandum* of plaintiffs in opposition to petition to intervene filed. Copies mailed 5-2-78.

5-3-78

22. *Answer* of deft. City of Akron, John S. Ballard, Dr. C. Wm. Keck, and Peter Oldham to petition to intervene of Francois Seguin, M.D. and Patricia K. Black filed. Copies mailed 5-3-78.

23. *Order* striking amended complaint. Plaintiffs shall be granted leave to amend their complaint by 5-8-78 at 9 a.m. Further, if plaintiffs seek to assert class action, they shall move for class certification by 5-12-78 & defts. shall respond thereby by 5-18-78 filed. Contie, J. Copies mailed 5-3-78.

24. *Motion* of plaintiffs to present affidavit of plaintiff Loe in a sealed envelope with memorandum in support and attachment filed. Copies mailed 5-3-78.

    Sealed Envelope bearing return address of American Civil Liberties Union of Ohio with true name affidavit of Linda Loe lodged.

5-4-78

25. *Motion* of plaintiffs for reconsideration of Court's order of 5-3-78 with Brief in support filed. (With attachments). Copies mailed 5-4-78.

5-5-78

26. *Order* denying motion of plaintiffs to reconsider Court's Order of 5-3-78 filed. Contie, J. Copies mailed 5-5-78.

5-8-78

27. *Second Amended Complaint* filed. Copies mailed 5-8-78.

5-10-78

28. *Motion* of plaintiffs to certify an Order pursuant to 28 U.S.C. § 1292(b) with Brief in support filed. Copies mailed 5-10-78.

5-15-78

29. *Motion* of plaintiffs to certify Order of 4-27-78 with Brief in support filed. Copies mailed 5-15-78.

5-16-78

30. *Order* that the Motion of Dr. Francois Seguin, M.D. & Patricia K. Black for leave to intervene as parties deft. is granted in part and denied in part filed. Contie, J. Copies mailed 5-16-78.

31. *Order* denying motion of plaintiffs for the Court to amend its Order of 4-27-78 certifying to USCA for the Sixth Circuit the question of propriety of denying physician leave to proceed by pseudonym filed. Contie, J. Copies mailed 5-16-78.

32. *Order* denying motion of plaintiffs for the Court to amend its Order of 5-3-78 to certify to USCA

for the Sixth Circuit the question of propriety of denying a pregnant woman leave to proceed by pseudonum filed. Contie, J. Copies mailed 5-16-78.

33. *Order* finding motion of plaintiffs to allow Linda Loe to proceed under pseudonym to be moot filed. Contie, J. Copies mailed 5-16-78.

34. *Order* finding motion of plaintiffs to certify this action as a class action on behalf of all physicians licensed to practice medicine in State of Ohio, within City of Akron, who do not or may in future terminate pregnancies by abortion to be moot filed. Contie, J. Copies mailed 5-16-78.

5-18-78

35. *Motion* of defendants to continue hearing on final merits & consent to a Temporary Injunction filed. Copies mailed 5-18-78.

5-19-78

36. *Answer* of intervenors Francois Seguin, M.D. & Patricia K. Black to Second Amended complaint filed. Copies mailed 5-19-78.

37. *Answer* of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck, and Peter Oldham filed. Copies mailed 5-19-78.

35. *Motion* of defendants to dismiss filed. Copies mailed 5-19-78.

39. *Memorandum* in support of defts' motion to dismiss filed. Copies mailed 5-19-78.

40. *Interrogatories* of defts. to pltf. Akron Center for Reproductive Health, Inc. filed. Copies mailed 5-19-78.

41. *Interrogatories* of defts. to pltf. WomenCare, Inc. filed. Copies mailed 5-19-78.

42. *Interrogatories* of defts. to pltf. Akron Women's Clinic, Inc. filed. Copies mailed 5-19-78.

43. *Motion* of defts. to have interrogatories answered within 3 days of service filed. Copies mailed 5-19-78.

44. *Motion* of plaintiffs to file a third amended complaint with memorandum in support and attachments filed. Copies mailed 5-19-78.

45. *Affidavit* of Stephan Landsman in opposition to motion to continue hearing filed. Copies mailed 5-18-78.

5-22-78

46. *Memorandum* of defendants in opposition to plaintiffs' motion to file a third amended complaint filed. Copies mailed 5-22-78.

5-23-78

47. *Order* granting motion of defts. for continuance of trial & action is hereby rescheduled for on or after 9-5-78. Further, all discovery shall be completed by 7-3-78 & all motions shall be filed by 7-17-78 filed. Contie, J. Copies mailed 5-23-78.

5-30-78

Endorsed Order overruling motion of defendants to have interrogatories answered within 3 days of service filed. Contie, J. Copies mailed 5-30-78.

6-2-78

48. *Requests* of plaintiffs for admissions to defts. City of Akron, Ballard, Keck & Oldham filed. (With attachments). Copies personally deliv. 6-2-78.

49. *Interrogatories* of plaintiffs to defts. City of Akron, Ballard, Keck & Oldham filed. Copies personally delivered 6-2-78.

50. *Request* of plaintiffs for admissions to defts. Seguin & Black filed. Copies personally delivered 6-2-78.

51. *Interrogatories* of plaintiffs to defts. Francois Seguin, M.D. & Patricia K. Black filed. Copies personally delivered 6-2-78.

6-5-78

52. *Notice* of change of address of Wayne G. Hawley, atty. for pltfs., filed. Copies mailed 6-1-78.

53. *Requests* of deft. City of Akron for admission to pltfs. filed. Copies mailed 6-2-78.

54. *Interrogatories* of deft. City of Akron (Second set) to pltfs. filed. Copies mailed 6-2-78 and copy hand delivered 6-2-78.

55. *Motion* of defts. requesting shorter time for responding to defts.' requests filed. Copies mailed 6-5-78.

56. *Request* (First) of defts. for production by pltf. Akron Center for Reproductive Health, Inc. filed. Copies mailed 6-2-78.

57. *Request* (First) of defts. for production by pltf. WomenCare, Inc. filed. Copies mailed 6-2-78.

58. *Request* (First) of defts. for production by pltf. Akron Women's Clinic, Inc. filed. Copies mailed 6-2-78.

59. *First Set* of Request for admissions by Intervenors to pltf. WomenCare, Inc. filed. Copies mailed 6-1-78.

60. *Request* for admissions (First set) by intervenor to pltf. Reproductive Health, Inc. filed. Copies mailed 6-1-78.

61. *Request* for admissions (First set) by intervenor to pltf. Akron Women's Clinic, Inc. filed. Copies mailed 6-1-78.

62. *Motion* of deft.-intervenors requesting shorter time for responding to deft.-intervenors' discovery requests filed. Copies mailed June 2, 1978.

63. *Request* of deft.-intervenors for production of documents & tangible things filed. Copies mailed 6-2-78.

64. *Interrogatories* (First set) of deft.-intervenors filed. Copies mailed 6-2-78.

65. *Requests* of deft.-intervenors (Second set) for admission filed. Copies mailed 6-2-78.

66. *Memorandum* of plaintiff in opposition to deft.'s motion to dismiss filed. Copies mailed 6-1-78.

6-7-78

67. *Notice* of defts. to take deposition of Norma M. Goldberger at 1:15 p.m. on 6-13-78 filed. Copies mailed 6-7-78.

68. *Notice* of defts. to take deposition of Kathy Gotshall at 9 a.m. on 6-13-78 filed. Copies mailed 6-7-78.

69. *Notice* of defts. to take deposition of Starlett C. Hurst at 10:30 a.m. on 6-13-78 filed. Copies mailed 6-7-78.

6-8-78

70. *Opposition* of plaintiffs to motion of deft.-intervenor to shorter time for discovery filed. Copies mailed 6-7-78.

6-12-78

71. *Supplemental Memorandum* of plaintiffs in opposition to defts.' motion to dismiss filed. Copies mailed 6-9-78.

72. *Brief* of intervenors in support of motion of deft.-intervenors to shorten time for responding to discovery requests filed. Copies mailed 6-12-78.

73. *Notice* of plaintiffs to take deposition of Roger Sherman at 1:30 p.m.; Dr. John Dettling, 2 p.m.; Dr. Wm. Cook, 3 p.m.; Dr. Edward F. Helwig, 4 p.m. on 6-28-78 filed. Copies mailed June, 1978 (Day omitted).

74. *Notice* of plaintiffs to take deposition of Robert Goehler at 9:30 a.m.; Ray Kapper, 11 a.m.; Alan G. Segedy, 1:30 p.m.; and Marvin Weinberger at 3 p.m. on 6-19-78 filed. Copies mailed June, 1978 (Day omitted).

75. *Returns* re (3) Deposition subpoenas filed. Served Norma M. Goldberger, Starlett C. Hurst, and Kathy Gotshall on 6-8-78. Fees $_____.

6-15-78

76. *Objection* of plaintiffs to inspection and copying of documents filed. Copies mailed 6-12-78.

6-16-78

77. *Reply* of plaintiffs to intervenors' brief in support of motion to shorten time filed. Copies mailed 6-15-78.

6-20-78

78. *Motion* of respondent, real parties in interest to quash subpoenas directed to real parties in

interest & for a protective order with Brief in support filed. Copies mailed 6-16-78.

6-21-78

79. *Application* of notary public, advice & instructions re: Deposition of Norma M. Goldberger filed.

80. *Application* of notary public, advice & instructions re: Deposition of Starlett C. Hurst filed.

81. *Application* of notary public, advice & instructions re: Deposition of Kathleen Gotshall filed.

6-23-78

82. *Motion* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham to compel Norma Goldberger to answer certain questions filed. Copies mailed 6-22-78.

83. *Affidavit* of James L. Bickett in support of Motion to compel filed. Copies mailed 6-22-78.

84. *Motion* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham to compel Starlett C. Hurst to answer certain questions filed. Copies mailed 6-22-78.

85. *Affidavit* of James L. Bickett in support of Motion to compel filed. Copies mailed 6-22-78.

86. *Motion* of defts. City of Akron, Dr. Keck, John Ballard, Peter D. Oldham for Order to compel Kathy Gotshall to answer certain questions filed. Copies mailed 6-22-78.

87. *Affidavit* of James L. Bickett in support of motion to compel filed. Copies mailed 6-22-78.

88. *Memorandum* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham in support of motion to compel filed. Copies mailed 6-22-78.

89. *Motion* of plaintiff to reconsider order denying certification filed. Copies mailed 6-22-78.

90. *Motion* to quash subpoenas issued to Dr. John Dettling and Dr. Wm. Cook or, in the alternative, motion to advance costs filed. Copies mailed 6-23-78.

91. *Affidavit* of Betty Ragan filed. Copies mailed 6-23-78.

92. *Affidavit* of Faith Lower filed. Copies mailed 6-23-78.

6-27-78

93. *Notice* of deposition of person designated by Department of Health of the State of Ohio on 7-3-78 at 10:00 a.m. Copies mailed 6-27-78.

94. *Return* re deposition subpoena (7) filed. Served Alan Segedy on 6-12-78, Robert C. Goehler on 6-12-78, Edward Helwig on 6-14-78, Roger Sherman at Children's Hospital on 6-15-78, Dr. John Dettling on 6-14-78, Dr. William Cook on 6-21-78, Marvin Weinberger on 6-13-78. Fees $_____.

6-28-78

95. *Response* of plaintiffs to first request for production propounded by city defendants filed. Copies mailed 6-27-78.

96. *Response* of plaintiffs to request for production of documents and tangible things propounded by defendant-intervenors filed. Copies mailed 6-27-78.

97. *Response* of plaintiffs to motion to quash subpoenas issued to Drs. Bettling and Cook filed. Copies mailed 6-27-78.

6-29-78

98. *Initial Response* of plaintiff to city defendants' motion to compel answers from deponent clinic directors filed. Copies mailed 6-28-78.

6-30-78

99. *Memorandum* of plaintiffs of points and authorities in opposition to non-party respondent's motion to quash subpoenas and for a protective order with attachments filed. Copy mailed 6-29-78.

100. *Responses* of plaintiff Akron Center for Reproductive Health, Inc. to first set of Interrogatories propounded by City defts. with attachment filed. Copies hand delivered 6-30-78.

101. *Responses* of pltf. Akron Center for Reproductive Health, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

102. *Response* of all plaintiffs to second set of interrogatories of City defendants filed. Copies hand delivered 6-30-78.

103. *Responses* of pltf. Akron Women's Clinic, Inc. to first set of interrogatories by City defendants filed. Copies hand delivered 6-30-78.

104. *Responses* of plaintiffs to intervenors' first set of requests for admissions filed. Copies hand delivered 6-30-78.

105. *Responses* of plaintiff WomenCare, Inc. to first set of interrogatories propounded by City defendants filed. Copies hand delivered 6-30-78.

106. *Response* of plaintiff WomenCare, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

107. *Responses* of plaintiffs to intervenors' second set of requests for admissions filed. Copies mailed 6-30-78.

108. *Response* of plaintiff Akron Women's Clinic, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

7-3-78

109. *Affirmation* in support of subpoena—respondents motion to quash and for a protective order filed. Copies mailed 6-30-78.

110. *Motion* of deft.-intervenors to compel answers to questions asked on oral deposition with memorandum in support filed. Copies mailed 7-3-78.

111. *Answers* of defts. Francois Seguin, M.D. & Patricia K. Black to plaintiff's interrogatories filed. Copies mailed 7-3-78.

112. *Answers* of defts. Francois Seguin, M.D. & Patricia K. Black to plaintiff's interrogatories filed. Copies mailed 7-3-78.

113. *Answers* to request for admission to defts. Seguin & Black filed. Copies mailed 7-3-78.

114. *Answers* of defendants to plaintiffs' interrogatories filed. Copies mailed 7-3-78.

115. *Answers* of defendants to plaintiffs' requests for admission filed. Copies mailed 7-3-78.

7-6-78

116. *Motion* of defendants to compel answers to interrogatories & to compel production of documents with Memorandum in support and Affidavit filed. Copies mailed 7-6-78.

7-7-78

117. *Oppostion* of plaintiffs to Motion to Compel Further Answers to Questions Aksed on Oral Deposition filed. Copy mailed 7-7-78.

7-11-78

118. *Affidavit* of Ruth Harris filed. Copies mailed 7-11-78.

7-13-78

119. *Order* denying motion of Raymond Kapper, Robert Goehler, Alan Segedy and Marvin Weinberger to quash subpoenas served on them and for a protective order filed. Copies mailed 7-13-78. Contie, J.

120. *Order* that motion of defendants and defendant-intervenor to compel answers and award of expenses be granted in part and denied in part. Motion for award of expenses is denied, Motion to compel answers are granted, with protective order filed. Contie, J. Copies mailed 7-13-78.

121. *Order* denying motion of plaintiffs for leave to file a third amended complaint filed. Contie, J. Copies mailed 7-13-78.

122. *Order* denying motion of Plaintiffs that Court reconsider order of 5-16-78 denying certification to the USCA for the Sixth Circuit filed. Contie, J. Copies mailed 7-13-78.

7-17-78

123. *Motion* of defendants for Partial Summary Judgment filed. Copies mailed 7-17-78.

124. *Motion* of Defendant-Intervenors to compel discovery with affidavit and Memorandum in

support filed. Copies mailed 7-15-78. (With attachments).

125. *Motion* of respondent for leave to file a reply to Plaintiffs' brief in opposition to respondents' motion to quash and for a protective order filed. Copies mailed 7-12-78.

126. *Brief* in support of Defendants' Motion for Partial Summary Judgment filed.

127. *Depositions* of Kathleen Gotshall, Starlett C. Hurst, and Norma C. Goldberger with attachments filed.

128. *Motion* for leave to proceed as amici curiae on behalf of plaintiffs filed. (With Memorandum in support). Copies mailed 7-17-78.

129. *Motion* of defendants to determine sufficiency of answers & objections to requests for admissions with memorandum in support filed. Copies mailed 7-17-78.

130. *Motion* of defendants to extend time to 8-11-78 for discovery with memorandum in support filed. Copies mailed 7-17-78.

131. *Motion* of plaintiffs to file fourth amended complaint with memorandum in support and attachment filed. Copies mailed 7-17-78.

132. *Motion* of plaintiffs for partial summary judgment with memorandum in support and attachments filed. Copies mailed 7-17-78.

133. *Motion* of plaintiffs for the setting of a date certain for hearing filed. Copies mailed 7-17-78. End. Ord. overruling motion 7-28-78. Copies mailed 7-28-78.

7-18-78

134. *Memorandum* of defendants City of Akron, John S. Ballard, Dr. C. William Keck and Peter Oldham in opposition to Plaintiffs' motion to file a fourth amended complaint filed. Copies mailed 7-18-78.

135. Defendants The City of Akron, John S. Ballard, Dr. C. William Keck and Peter Oldham, response to Plaintiffs' Motion for the setting of a date certain filed. Copies mailed 7-18-78.

7-20-78

136. *Response* of plaintiffs to motion of city defendants to compel answers to interrogatories and to compel production of documents filed. Copies mailed 7-18-78.

7-24-78

137. *Response* of all plaintiffs to City Defendants' Requests for Admissions filed. Copies mailed 7-20-78.

7-26-78

138. *Memorandum* of plaintiffs in opposition to city defendants' motion for partial summary judgment filed. Copies mailed 7-25-78.

139. *Memorandum* of plaintiffs in opposition to city defendants' motion to determine sufficiency of answers and objections to requests for admissions filed. Copies mailed 7-25-78.

140. *Application* ex parte for order enlarging time filed. Copies mailed 7-26-78.

7-27-78

141. *Memorandum* of plaintiffs in opposition to defendant-intervenors' motion to compel discovery filed. Copies mailed 7-26-78.

142. *Order* granting enlargement of time on ex parte application of defendants, and extending time to 8-2-78 filed. Contie, J. Copies mailed 7-28-78.

7-28-78

143. *Memorandum* of defendants in opposition to motion for leave to proceed as Amici Curiae on behalf of plaintiffs filed. Copies mailed 7-20-78.

144. *Order* granting motion of defendants to extend discovery to 8-11-78 filed. Contie, J. Copies mailed 7-28-78.

145. *Order* granting request of Raymond Kapper, Robert Goehler, Alan Segedy, and Marvin Weinberger to withdraw Brief in opposition to motion to quash and for a protective order filed. Contie, J. Copies mailed 7-28-78.

146. *Order* granting motion of plaintiffs for leave to file a fourth amended complaint filed. Contie, J. Copies mailed 7-28-78.

147. *Fourth Amended Complaint* of plaintiffs filed. No service.

148. *Order* granting National Abortion Rights League and the American Public Health Association leave to proceed as amici curiae to file brief in pltfs.' behalf. Also, denying unnamed individual physicians and health professionals leave to proceed as amici curiae. Also, physicians and health professionals have 10 days to file motion to proceed as amici curiae in accordance with conditions filed. Contie, J. Copies mailed 7-28-78.

7-31-78

149. *Brief* of defendant-intervenors in opposition to plaintiffs' motion for partial summary judgment filed.

150. *Request* of plaintiff for production of documents from city defts. filed. Copies mailed 7-28-78.

151. *Motion* of deft. to reconsider Order permitting Amici Curiae to proceed filed. Copies mailed 7-31-78.

8-1-78

152. *Motion* of plaintiffs for Ellen Leitzet to appear as counsel filed. Copies mailed 7-31-78. End. Ord. Granting. Contie, J. Copies mailed 8-22-78.

8-2-78

153. *Order* denying motion of Defendant-Intervenors to compel discovery filed. Contie, J.

154. *Order* denying in part, and granting in part, defendant's motion to compel discovery. Pltfs. must respond to #8, 12, 16, 21, 24, & 27 of defts.' 1st set of interrogatories, and #21 & 22b of defts.' 2nd set of interrogatories within 5 days of date of order. Further, pltfs. must produce documents in categories 1-5 of defts.' 1st request for prod. of documents within 5 days of date of order filed. Contie, J.

8-1-78

155. *Order* granting defts.' motion to determine Sufficiency of Answers and Objections to Requests for Admissions. Pltfs. ordered to respond to #12, 13, 14, 15, 16, 17, 19, & 56 of defts.' request for admissions within 5 days of date of order filed. Contie, J. Copies mailed 8-1-79.

8-2-78

156. *Brief* of Defendant-Intervenors in support of defendant's Motion for Summary Judgment filed. (With affidavit and attachments). Copies mailed 8-2-78.

157. *Memorandum* of defendants in opposition to plaintiffs' motion for partial summary judgment filed. Copies mailed 8-2-78.

158. *Notice* of deposition of defendants of Dr. Robert Bliss, M.D. on 8-9-78, at 2 p.m. filed. Copies mailed 8-2-78.

8-7-78

159. *Answer* of defts. City of Akron, John S. Ballard, Dr. C. William Keck, and Peter Oldham filed. Copies mailed 8-7-78.

8-14-78

160. *Answer* of intervenors to Fourth Amended complaint filed. Copies mailed 8-14-78.

8-17-78

161. *Motion* of Applicants for enlargement of time to file motion to proceed as amici curiae on behalf of plaintiffs with memorandum in support filed.

8-18-78

162. *Order* denying motions of defts. and deft.-intervenors' requests for a shorter time for responding to defendant-intervenors. Discovery Requests filed. Contie, J. Copies mailed 8-22-78.

163. *Order* denying motion of defts. to reconsider order of 7-28-78 granting NARAL and APHA leave to proceed as amici curiae filed. Contie, J. Copies mailed 8-22-78.

164. *Order* denying motion of deft. without prejudice to seek dismissal of plaintiffs' fourth amended complaint for lack of standing filed. Contie, J. Copies mailed 8-22-78.

8-23-78

165. *Supplemental Responses* of plaintiffs to first and second set of interrogatories propounded by city defendants filed.

166. *Supplemental Response* of plaintiffs to city defendants' first request for production filed. Copies mailed 8-22-78.

8-24-78

167. *Order* granting motion of applicants extension of time to file motion to proceed as amici curiae filed. Contie, J.

168. *Motion* of applicants for leave to proceed amici curiae with attachments filed.

169. *Order* that individual physicians and health professionals named in attached list have leave to proceed as amici curiae and join with NARAL and APHA in filing brief on behalf of plaintiffs filed. Contie, J. Copies mailed 8-25-78.

170. *Order* denying motions of pltf. and deft. for partial summary judgment filed. Contie, J. Copies mailed 8-25-78.

8-28-78

171. *Deposition* of Marvin Weinberger taken on 8-2-78 at 3:17 p.m. with attachments filed. Fees $____.

172. *Deposition* of Ray Kapper, President of Akron City Council taken 8-2-78 at 9:40 a.m. filed. Fees $_____. (With attachments).

173. *Deposition* of Alan G. Segedy taken on 8-2-78 at 12:44 p.m. with attachments filed. Fees $_____.

174. *Deposition* of Robert Goehler taken on 8-3-78 at 9:50 a.m. with attachments filed. Fees $____.

8-29-78

175. *Motion* for leave to file a motion with memorandum in support filed. Copies mailed, no date.

176. *Deposition* of Roseann Doria taken on 8-10-78 at 9:15 a.m. filed. Fees $_____.

177. *Deposition* of Kathleen Gotshall taken on 8-11-78 at 9:45 a.m. filed. Fees $_____.

178. *Deposition* of Starlett C. Hurst taken on 8-10-78 at 3:50 a.m. filed. Fees $_____.

179. *Deposition* of Norma Goldberger taken on 8-10-78 at 11:31 filed. Fees $_____.

180. *Deposition* of Robert T. Bliss, M.D. taken on 8-15-78 at 3:34 p.m. filed. Fees $_____.

181. *Deposition* of Rein Siiner, M.D. taken on 8-8-78 at 11:05 a.m. filed. Fees $_____.

182. *Memorandum* in support of motion to dismiss Dr. Robert Bliss, Akron Center for Reproductive Health, Inc., Akron Women's Clinic Inc., and WomenCare, Inc. (3 copies) filed. All copies ***under seal.***

8-30-78

183. *Order* that complete trial briefs, stipulation (if any), 2 copies of all exhibits, copy of what counsel believes are issues, proposed findings of fact, conclusions of law, list of proposed witnesses are to be submitted to the Court forthwith. Further, exhibits to be marked before trial, pltf. using numbers, and deft. using letters filed. Copies mailed 8-30-78.

184. *Order* denying motion of defts. to dismiss filed. Copies mailed 8-30-78.

8-31-78

185. *Motion* of deft.-intervenors for leave to permit James Bopp, Jr., to appear as counsel with attachment filed. Copies mailed 8-31-78. 8-31-78 End. Order granting motion. Contie, J.

9-1-78

186. *Trial Brief* of intervenors filed. (With attachments). No service.

187. *Index* to deft.'s exhibits filed. No service.

188. *List* of defendant-intervenors of basic issues to be determined in this action filed. No service.

189. *Witnesses* to be called by defendant-intervenors ***under seal*** filed.

190. *Findings* of fact of defendant-intervenors filed. No service.

191. *Proposed Conclusions* of law of defendant-intervenors filed. No service.

192. *Index* of defendant's exhibits filed. No service. (***under seal***).

193. *Witnesses* to be called by defendant filed. No service.

194. *Pretrial Brief* of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck and Peter Oldham filed. No service.

195. *Statement* of issues of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck & Peter Oldham filed. No service.

196. *Trial Brief* of plaintiffs filed. No service.

197. *Supplemental Responses* of plaintiffs to city defendants' request for admissions filed. Copies mailed 9-1-78.

9-5-78

198. *Proposed Findings* of facts and conclusions of law of Defts. Ballard, Keck and Oldham filed.

199. *Return* re (7) Subpoena to Produce Document or Object filed. Served Dr. Gary Benfield on 9-5-78, Nancy L. Walker on 9-__-78, Betty Ragan on 9-2-78, John S. Ballard, Mayor of Akron, on 9-2-78, Dr. Charles Bowen on 9-1-78, Dr. C. William Keck on 9-2-78, and Joyce Bender on 9-2-78. Fees $_____.

200. *Return* re Civil Subpoenas (3) filed. Served Reginald Brooks on 9-1-78, Alan Segedy, and Ray Kapper on 9-1-78. Fees $_____.

9-13-78

201. *Deposition* of Francine Lucas taken on 8-8-78 at 9:15 a.m. filed.

202. *Deposition* of Dr. A. taken on 8-9-78 at 10:43 a.m. filed. ***Under seal.***

203. *Deposition* of Dr. B. taken on 8-17-78 at 11:08 a.m. filed. ***Under seal.***

9-19-78

204. *Order* finding motion of Drs. John Dettling & Wm. Cook to quash subpoenas filed by plaintiffs directing production of certain hospital records to be moot filed. Contie, J.

9-20-78

205. *Minutes* of proceedings filed. Contie, J. Kreitzburg, Tedrahn, Purser, Thompson, r. Tried by

the Court on Sept. 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 1978. Total trial time: 47 hrs., 10 min.

9-21-78

206. *Motion* for leave to proceed as amici curiae filed. Copies mailed 9-21-78.

9-25-78

207. *Order* that the physicians and health professionals named in list submitted to the Court may join in filing brief on behalf of plaintiffs filed. Contie, J.

9-26-78

208. *Marshal's Return* re Civil Subpoena filed. Served Francine Lucas on 9-13-78. Fees $2.48.

209. *Marshal's Return* re (6) Civil Subpoenas filed. Served Dr. A. on 9-12-78, As To Dr. B, RTUX. Served Robin Ratcliff on 9-13-78, Starlett Hurst on 9-11-78, Dr. Rein Siiner on 9-11-78, and Kathleen Gottshall on 9-11-78. Fees $12.85.

210. *Marshal's Return* re Subpoena to Produce Documents of objects filed. Served Norma Goldberger on 9-12-78. Fees $2.48.

9-27-78

211. *Marshal's Return* re Civil Subpoena filed. Served Kathryn Bajo on 9-__-78. Fees $3.00.

10-11-78

212. *Transcript* of proceedings before Judge Contie 9-5-78 (Vol. 1) filed. Purser, r.

213. *Transcript* of proceedings before Judge Contie 9-6-78 (Vol. 2) filed. Purser, r.

214. *Transcript* of proceedings before Judge Contie 9-7-78 (Vol. 3) filed. Tedrahn, r.

215. *Transcript* of proceedings before Judge Contie 9-8-78 at 9:15 a.m. (Vol. 4) filed. Tedrahn, r.

216. *Transcript* of proceedings before Judge Contie 9-11-78 (Vol. 5) filed. Kreitzburg, r.

217. *Transcript* of proceedings before Judge Contie 9-12-78 at 9 a.m. (Vol. 6) filed. Kreitzburg, r.

218. *Transcript* of proceedings before Judge Contie 9-13-78 (Vol. 7) filed. Prather, r.

219. *Transcript* of proceedings before Judge Contie 9-14-78 (Vol. 8) filed. Prather, r.

220. *Transcript* of proceedings before Judge Contie 9-15-78 at 9 a.m. (Vol. 9) filed. Christy, r.

221. *Transcript* of proceedings before Judge Contie 9-15-78 at 9 a.m. (Vol. 10) filed. Christy, r.

10-24-78

222. *Motion* of defts. City of Akron, John Ballard, Dr. C. Wm. Keck, & Peter Oldham & Deft.-Intervenors Francois Seguin, M.D. & Patricia K. Black for extension of time of 14 days to file briefs, after receipt of final portion of transcript filed (With Memorandum in support). Copies mailed Oct. 1978 (Day omitted).

10-25-78

223. *Order* vacating previously established briefing scheduled. Post-trial briefs of all parties shall be due on 11-15-78. Any reply briefs the parties deem appropriate shall be due by 11-30-78 filed. Contie, j. Copies mailed 10-25-78.

11-13-78

224. *Brief* of defts. City of Akron, John S. Ballard, Dr. Keck & Peter Oldham filed. Copies mailed 11-13-78.

11-15-78

225. *Post-trial Brief* of plaintiffs filed. (With attachment). Copies delivered 11-15-78.

226. *Brief* of deft.-intervenors as parties and as Amici Curiae (Part I) with attachments filed. Copies served 11-15-78.

227. *Post-trial Brief* of defendant-intervenors (Part II) filed. Copy hand delivered 11-15-78.

11-27-78

228. *Minutes* of proceedings filed. Contie, J. Supplee, r. Heard by the Court Nov. 27, 1978. Total trial time: 5 hrs. Preliminary injunction hearing.

11-29-78

229. *Reply Brief* of defendants City of Akron, John S. Ballard, Dr. C. Wm. Keck & Peter Oldham filed. Copies mailed 11-29-78.

230. *Response* of defendant-intervenors to plaintiffs' post-trial brief filed. Copies mailed 11-29-78.

11-30-78

231. *Post-trial Reply Brief* of plaintiffs (copy) filed. (With attachments). Copies mailed 11-29-78.

12-7-78

232. *Brief* of Amici Curiae in support of plaintiffs with attachments filed. (Copy). Copies mailed (Date omitted).

1-31-79

233. *Motion* of deft. & deft.-intervenors for leave to file Briefs filed. Copies mailed 1-31-79.

2-1-79

234. *Order* granting motion of defts. & deft.-intervenors that all parties file post-trial briefs on

impact, if any, of Supreme Court's decision in *Colautti* by 3-5-79. Any reply briefs by 3-19-79 filed. Contie, J. Copies mailed 2-1-79.

3-1-79

235. *Supplemental Brief* of deft. City of Akron filed. Copies mailed 3-1-79.

3-5-79

236. *Brief* of Defendant-Intervenors re *Colautti v. Franklin* filed. Copies mailed 3-5-79.

3-7-79

237. *Supplementary Brief* of plaintiffs concerning *Colautti v. Franklin* filed. Copies mailed 3-5-79.

3-19-79

238. *Answer Brief* of defendant, City of Akron filed. Copy mailed 3-__-79.

239. *Reply Brief* of deft.-intervenors to supplementary brief concerning *Colautti v. Franklin* of plaintiffs filed. Copies mailed 3-19-79.

3-30-79

240. *Entry* of appearance of Gordon J. Beggs on behalf of pltfs. in substitution for Wayne G. Hawley filed. Copy mailed 3-29-79.

5-7-79

241. *Letter* from Stephan Landsman to the Hon. Leroy Contie, Jr. bringing two recent decisions to attention of the Court filed.

5-24-79

242. *Supplemental Brief* of deft.-intervenors filed. Copy served 5-23-79.

7-10-79

243. *Motion* of deft.-intervenors Seguin & Black for leave to file brief as to *Bellotti v. Baird* filed. Copies mailed 7-10-79.

244. *Order* granting motion of deft.-intervenors for leave to file briefs on Supreme Court's decision in *Bellotti v. Baird* by 7-23-79 filed. Contie, J. Copies mailed 7-11-79.

7-23-79

245. *Brief* of deft.-intervenors re *Bellotti v. Baird* filed. Copies mailed 7-23-79.

246. *Suppemental Brief* of deft. filed. Copies mailed 7-23-79.

7-25-79

247. *Supplementary Brief* of plaintiff re *Bellotti v. Baird* filed. Copy mailed 7-23-79.

8-6-79

248. *Reply* of deft.-intervenor to pltf.'s supplementary brief re *Bellotti v. Baird* filed. Copies mailed 8-2-79.

8-15-79

249. *Response* of plaintiffs to Intervenors' Second Brief concerning *Bellotti v. Baird* filed. Copies mailed 8-14-79.

8-22-79

250. *Memorandum, Opinion and Order* filed. Contie, J. Copies hand delivered 8-22-79.

251. *Judgment Entry* filed. Contie, J. Copies hand delivered 8-22-79.

8-31-79

252. *Motion* of plaintiffs for new trial or in alternative, to alter or amend the judgment with memorandum in support filed. Copy mailed 8-31-79.

9-7-79

253. *Notice* of appeal of defts. Francois Seguin, M.D. & Patricia K. Black—appellants filed. No service. Copies mailed by the Clerk 9-10-79.

9-12-79

254. *Memorandum* of deft.-intervenors in opposition to pltfs.' motion for new trial or in alternative to alter or amend judgment filed. Copies mailed 9-12-79.

9-17-79

255. *Memorandum* of defts. in opposition to motion for new trial or to alter or amend judgment filed. Copies mailed 9-15-79.

9-18-79

256. *Motion* of plaintiffs for Order that record be retained in District Court with memorandum in support filed. Copies mailed 9-17-79.

9-17-79

257. *Certificate* re transcript of proceedings by deft.-appellants filed. Copies mailed 9-17-79.

9-20-79

258. *Order* granting motion of plaintiffs for Order that record be retained in the District Court filed. Contie, J. Copies mailed 9-20-79.

9-19-79

259. *Reply* of plaintiffs to intervenors' memorandum in opposition to plaintiffs' motion for new trial filed. Copies mailed 9-19-79.

260. *Notice* of appeal of pltfs.-appellants filed. Notice mailed by Clerk 9-21-79.

9-28-79

261. *Order* striking Notice of appeal filed on 9-19-79 filed. Contie, J. Copies mailed 9-28-79.

10-3-79

262. *Rejoinder* of deft.-intervenors to pltfs.' reply to intervenors' memorandum in opposition to pltfs.' motion for new trial filed. Copies mailed 10-2-79.

10-4-79

263. *Order* that plaintiffs' Motion for new trial or in the alternative to alter or amend the judgment is granted in part and denied in part filed. Contie, J. Copies mailed 10-5-79.

10-15-79

264. *Motion* of plaintiffs for award of attorneys' fees with memorandum in support and attachment—$61,125.00 filed. Copies mailed 10-15-79.

265. *Bill* of costs of plaintiffs—$4,079.35 filed. Copies mailed 10-15-79. Costs of $4,079.35 taxed by Cleark 10-30-79. Copies mailed 10-30-79.

10-19-79

266. *Letter* from Alan G. Segedy indicating parties consent to extension of time for filing responsive brief to pltfs.' motion for attys.' fees filed.

267. *Letter* from Gordon J. Beggs for release of $100.00 TRO bond filed.

268. *Order* granting deft.-intervenors leave to file written statements of reasons in opposition to pltfs.' motion for award of attys.' fees to 11-15-79 filed. Contie, J. Copies mailed 10-19-79.

269. *Order* that Clerk release $100.00 cash TRO Bond to Stephan A. Landsman filed. Contie, J. Original and copy mailed 10-19-79.

10-22-79

270. *Acknowledgment* of receipt of Notices of Appeal by USCA for the Sixth Circuit filed. Case Nos. 79-3650 and 79-3651 filed 10-22-79.

271. *Order* granting deft.-intervenors leave to 11-5-79 to serve & file written statements of reasons in opposition to pltfs.' motion for award of attorneys' fees filed. Contie, J. Copies mailed _____.

10-25-79

272. *Notice* of change of address of attorney James L. Bickett, atty. for defts. filed. Copies mailed Oct. 1979 (Day omitted).

273. *Memorandum* of defts. in opposition to pltf.'s motion for atty.'s fees filed. Copies mailed Oct. 1979 (day omitted).

10-29-79

274. *Motion* of defts. City of Akron, John S. Ballard, Dr. Keck & Peter O. Oldham for attorney's fees & costs of $28,508.99 with memorandum and attachments in support filed. Copies mailed 10-29-79.

275. *Order* amending Order of 10-19-79 releasing $100.00 TRO bond filed. Contie, J. Original and copy mailed 10-29-79.

10-30-79

276. *Notice* of appeal of intervening defts.-appellants filed. Notice mailed by the Clerk 10-30-79.

10-31-79

277. *Affidavit* of Wayne Hawley filed. No service.

278. *Affidavit* of Patricia S. Roberts filed. No service.

11-1-79

279. *Order* granting pltf.'s leave to consolidate their Reply to defts.' memorandum in opposition to pltfs.' motion for atty.'s fees with their reply to deft.-intervenors' memorandum on same subject to be filed within 10 days of service of deft.-intervenors' memorandum upon pltfs. filed. Contie, J. Copies mailed 11-1-79.

11-5-79

280. *Affidavit* of Ellen Leitzer filed. No service.

281. *Order* granting pltfs. leave to consolidate their Reply to defts.' Motion for atty.'s fees with their Reply to deft.-intervenors' memorandum on subject of pltfs.' motion for atty.'s fees to be filed within 10 days of service of deft.-intervenors' memorandum upon pltfs. filed. Contie, J. Copies mailed 11-6-79.

11-7-79

282. *Certificate* of deft.-intervenors re transcript of proceedings filed. Copies mailed 11-7-79.

11-9-79

283. *Letter* (copy) from Alan G. Segedy to Stephan Landsman re appeal filed.

11-13-79

Certified Original Pleadings mailed to USCA for the Sixth Circuit.

284. *Notice* of Appeal of plaintiffs-appellants filed. Copy of this pleading with copy of docket sheet mailed to USCA for the Sixth Circuit 11-13-79.

11-14-79

285. *Motion* of deft. City of Akron for extension of time for filing Notice of appeal filed. Copies mailed November, 1979 (day omitted).

11-15-79

Omnibus Response of pltfs.' concerning atty.'s fees and costs filed. Copies mailed 11-15-79.

11-20-79

286. *Brief* of deft. City of Akron in support of its motion to extend time for filing Notice of Appeal filed. Copy mailed 11-19-79.

287. *Affidavit* of Vic Dandrea filed.

11-21-79

288. *Designation* of plaintiffs that no further transcript materials are to be ordered from the reporter and entire transcript is to be part of record filed. Copies mailed 11-21-79.

11-28-79

Motion of deft.-intervenors for leave to filed Reply to pltfs.' omnibus response concerning atty.'s fees & costs with attachments filed. Copies mailed 11-27-79. 11-28-79 Endorsed Order granting motion. Contie, J. Copies mailed 11-28-79.

12-4-79

289. *Order* granting motion of deft. City of Akron for extension of time to file Notice of appeal filed. Contie, J. Copies mailed 12-5-79.

290. *Notice* of appeal of deft.-appellant City of Akron filed. Copies mailed Nov. 1979 (Day omitted). Copies mailed by Clerk to all counsel 12-11-79.

12-11-79

291. *Certificate* re transcript of proceedings & designation of record by defts. City of Akron, John S. Ballard, Dr. Wm. Keck & Peter Oldham filed. Copies mailed 12-12-79.

Supplemental Pleadings 285-291 mailed to USCA for th Sixth Circuit.

MOTION OF PLAINTIFF TO PRESENT AFFIDAVIT OF PLAINTIFF DR. DOE IN A SEALED ENVELOPE WITH MEMORANDUM IN SUPPORT AND AN AFFIDAVIT OF DR. DOE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: April 19, 1978]

DR. DOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF DOE IN A SEALED ENVELOPE

Plaintiffs hereby move the Court that due to the sensitive nature of the matters contained in the accompanying complaint the true name affidavit of plaintiff Dr. Doe (a pseudonym), presented to the Court concurrently herewith, be held by the Court in a sealed envelope to preserve the anonymity of Dr. Doe and that Dr. Doe be allowed to continue in this case under this pseudonym.

Plaintiffs attach hereto in support of this motion a memorandum of law and an affidavit by Dr. Doe.

Respectfully submitted,

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Janet Benshoof
American Civil Liberties Union
Reproductive Freedom Project
22 East 40th Street
New York, New York 10016
(212) 725-1222

Robert P. App
American Civil Liberties Union
of Ohio Foundation, Inc.
203 East Broad Street
Columbus, Ohio 43215
(614) 228-8951

Patricia A. Vance
34 North Hawkins Avenue
Akron, Ohio 44312
(216) 836-9358

Dennis Haines
Patricia S. Roberts
4th Floor, Dollar Bank Building
Post Office Box 849
Youngstown, Ohio 44501
(216) 743-5101

Wayne G. Hawley
American Civil Liberties Union
of Cleveland, Inc.
2108 Payne Avenue, Suite 507
Cleveland, Ohio 44114
(216) 781-6276

Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

MEMORANDUM IN SUPPORT OF MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF DOE IN A SEALED ENVELOPE

Because of the sensitive and controversial nature of the matters involved in this case and because of the

severe personal, professional and economic consequences which revealing his/her identity would cause Dr. Doe, plaintiff Doe should be able to remain in the case under a pseudonym. See *Roe v. Wade*, 410 U.S. 113, 124 (1973); *Coe v. Gerstein*, 376 F. Supp. 695, 696 (S.D. Fla. 1973).

Respectfully submitted,

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Janet Benshoof
American Civil Liberties Union
Reproductive Freedom Project
22 East 40th Street
New York, New York 10016
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American Civil Liberties Union
of Ohio Foundation, Inc.
203 East Broad Street
Columbus, Ohio 43215
(614) 228-8951

Patricia A. Vance
34 North Hawkins Avenue
Akron, Ohio 44312
(216) 836-9358

Dennis Haines
Patricia S. Roberts
4th Floor, Dollar Bank Building
Post Office Box 849
Youngstown, Ohio 44501
(216) 743-5101

Wayne G. Hawley
American Civil Liberties Union
of Cleveland, Inc.
2108 Payne Avenue, Suite 507
Cleveland, Ohio 44114
(216) 781-6276

Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

SEALED AFFIDAVIT OF DR. DOE

I, Doctor Doe (a pseudonym), being duly sworn, depose and say:

1. I request the Court to allow me to file an affidavit, revealing my true identity, in a sealed envelope and to continue in this suit under the pseudonym of Dr. Doe. I make this request because of the severe personal, professional and economic consequences which revealing my identity would cause, as set forth in detail for the Court in the sealed affidavit.

2. I am a physician licensed by the State of Ohio, and am a board-certified specialist in obstetrics and gynecology.

3. I have in the past and intend in the future to perform abortions within the City of Akron.

4. I fear that I will be prosecuted if I perform an abortion on or after May 1, 1978, without complying with the provisions of Ordinance No. 160-78.

5. I will lose income because of Ordinance No. 160-78, because the ordinance will deter my patients from seeking abortions within the City of Akron.

6. I wish to assert my rights as a physician, the rights of my fellow physicians, and the rights of the patients whom we will serve against interference from Ordinance No. 160-78.

7. Ordinance No. 160-78 interferes with the following rights of myself and my patients:

a. Section 1870.03 (Abortion in Hospital) is a regulation of the second trimester procedure, which, in the case of early second trimester procedures, is not reasonably related to protection of maternal health, and which therefore impermissibly interferes with my

patient's privacy and my right to practice medicine. I may in the future perform an early second trimester procedure outside of a hospital, if permitted by law.

b. Section 1870.04 (Abortion after Viability) establishes a presumption of viability without any reasonable relationship to reality; may require a procedure more dangerous to the pregnant woman where that presumption exists, with no reasonable benefit to the potential for life; and requires a second physician where not medically necessary; in fact, a single obstetrician handles premature birth of a child at any stage of the pregnancy. This section endangers the woman's life and interferes with the physician's right to practice. I may in the future, if requested, perform an abortion for a woman 22 weeks pregnant.

c. Section 1870.05 (Notice and Consent) would require me to violate my duty to maintain my patients' confidentiality by notifying third parties. I presently determine, for any patient of any age, whether she is mature and competent enough to give knowing, voluntary consent to the medical procedure. If I determine that she is, I give her all the information which is necessary for her consent to be informed, including the nature of the procedure, its risks and benefits, and the alternatives. This section interferes with my patients' right of privacy, the physician-patient relationship, and my right to practice medicine.

d. Section 1870.06 (Informed Consent) interferes with my obligation to tailor the information which I give a patient to her particular best interest. The statement that "the unborn child is a human life from the moment of conception" is not scientifically sound. I consider it a religious statement, and object to the City's requiring me or any physician to give it, or our

patients to hear it. The survival of a fetus born or aborted at 22 weeks gestation is extremely unlikely and the usual and customary medical treatment of a case at that stage in the pregnancy is that of a spontaneous miscarriage, for which no attempt at resuscitation is made. To give such inaccurate advice about viability is not only confusing, because usually irrelevant, but medically irresponsible. Abortion is not a major surgical procedure. To give such information is also irresponsible. The entire section interferes with the patients' right to privacy, with the physician-patient relationship, and with the physician's right to practice medicine.

e. Section 1870.07 (Waiting Period) would have caused unnecessary anxiety for some women for whom I have performed abortions, because these women had already made a careful, informed decision to terminate their pregnancies and neither desired nor required any waiting. I will suggest a waiting period before any surgical procedure when the patient manifests such ambivalence about her decision that she seems not truly to have decided. I consider this section an unwarranted invasion of patients' right to treatment, as well as an interference with my right to practice.

f. Section 1870.09 (Inspection) could endanger the health of my patients. I perform abortions and other minor surgical procedures, in facilities which are not open to the public, so that intrusions of strangers are definitely not expected. Such intrusions during any surgical procedure could endanger a patient's health. I also object to complete access by inspectors to the private medical records of all my patients. I consider this section an unwarranted invasion of my patient's right to privacy.

g. Section 1870.10 (Reporting) duplicates a report which I have executed for each abortion which I have performed, and which report I send to the State of Ohio. I object to this duplication as an unnecessary burden on the abortion procedure.

I say nothing further.

/s/ Dr. Doe
(a pseudonym)

[SEAL]
STATE OF OHIO:
SUMMIT COUNTY:

Dr. Doe personally appeared before me this 14th day of April, 1978 and upon oath states that the foregoing is true to the best of his knowledge.

/s/ Patricia A. Vance
Notary Public

MOTION OF PLAINTIFFS TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE WITH MEMORANDUM IN SUPPORT AND AN AFFIDAVIT OF LINDA LOE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 8, 1978]

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE

Plaintiffs hereby move the Court that due to the sensitive nature of the matters contained in this action the true name affidavit of plaintiff Linda Loe (a pseudonym), presented to the Court concurrently herewith, be held by the Court in a sealed envelope to preserve the anonymity of Linda Loe and that Linda Loe be allowed to continue in this case under this pseudonym. Plaintiffs

attach hereto in support of this motion a memorandum of law and an affidavit of Linda Loe.

Respectfully submitted,

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Janet Benshoof
American Civil Liberties Union
Reproductive Freedom Project
22 East 40th Street
New York, New York 10016
(212) 725-1222

Robert P. App
American Civil Liberties Union
of Ohio Foundation, Inc.
203 East Broad Street
Columbus, Ohio 43215
(614) 228-8951

Patricia A. Vance
34 North Hawkins Avenue
Akron, Ohio 44312
(216) 836-9358

Dennis Haines
Patricia S. Roberts
4th Floor, Dollar Bank Building
Post Office Box 849
Youngstown, Ohio 44501
(216) 743-5101

Wayne G. Hawley
American Civil Liberties Union
of Cleveland, Inc.
2108 Payne Avenue, Suite 507
Cleveland, Ohio 44114
(216) 781-6276

Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

MEMORANDUM IN SUPPORT OF MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE

Because of the sensitive and personal nature of the matters involved in this case and because of the severe psychological and emotional consequences which reveal-

ing her identity would cause her, plaintiff Loe should be able to remain in the case under a pseudonum.

Courts have routinely permitted pregnant women challenging abortion regulations to proceed under pseudonyms. See *Roe v. Wade*, 410 U.S. 113, 124 (1973); *Doe v. Bolton*, 410 U.S. 179, 187 (1973); *Coe v. Gerstein*, 376 F. Supp. 695, 696 (S.D. Fla. 1973); and *Lady Jane v. Maher*, 420 F. Supp. 318 (D. Conn. 1976).

The earlier decision in *Roe v. State of New York*, 49 F.R.D. 279 (S.D.N.Y. 1970), is distinguishable because that case did not involve private sexual matters and because the court there emphasized its desire to have "at least one plaintiff" identified by his true name. Three of the four plaintiffs here do reveal their true name.

For these reasons plaintiff Loe should be permitted to protect her intimate privacy by proceeding under a pseudonum.

Respectfully submitted,

(By) /s/ Wayne G. Hawley

Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Janet Benshoof
American Civil Liberties Union
Reproductive Freedom Project
22 East 40th Street
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Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

STATE OF OHIO
COUNTY OF SUMMIT

Before Judge Contie

AFFIDAVIT OF LINDA LOE
(a pseudonym)

I, Linda Loe (a pseudonym), being duly sworn, depose and say:

1. I am a woman with children residing in the City of Akron. I am presently in the tenth week of pregnancy and I desire to terminate my pregnancy by an abortion. I intend to do so within the City of Akron.

2. I wish to be a plaintiff in this lawsuit to assert my constitutional rights, and the rights of all women, pregnant now and in the future, who wish to terminate their pregnancies within the City of Akron.

3. I have read the First Amended Complaint. The facts therein are true and accurate to the best of my knowledge.

4. I request the Court to allow me to file an affidavit, revealing my true identity, in a sealed envelope and to continue in this suit under the pseudonym of Linda Loe. I make this request because of the sensitive, private nature of my decision and because of the humiliation which I would feel if my identity were publicly known.

I say nothing further.

/s/ Linda Loe
(a pseudonym)

Sworn to and subscribed before me this 3rd day of May, 1978 at Akron, Ohio.

/s/ Wayne G. Hawley
Notary Public
(My commission has no expiration date.)

CERTIFICATE OF SERVICE

A copy of the foregoing Motion to Present Affidavit of Plaintiff Loe in a Sealed Envelope was mailed this 3rd

day of May, 1978 to James L. Bickett, 304 Municipal Building, Akron, Ohio 44308 and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio 44308.

/s/ Wayne G. Hawley

SEALED AFFIDAVIT OF DR. DOE TO PROCEED BY PSEUDONYM WITH DELETIONS

[Logged: April 13, 1978]

Cleveland State University
Cleveland-Marshall College of Law
Cleveland, Ohio 44115

SEALED TRUE NAME AFFIDAVIT OF DR. DOE

FOR THE COURT'S EYES *ONLY*

I, being duly sworn, depose and say:

1. I am a physician duly licensed by the State of Ohio, and am a board-certified specialist in obstetrics and gynecology.

2. I am medical director of Plaintiff, . I perform now, and intend to perform in the future, within the City of Akron, abortion procedures by the suction curettage method for women on an out-patient basis through the twelfth week of gestation.

3. I wish to appear as a Plaintiff in this litigation, in order to assert my rights, the rights of my fellow physicians, and the rights of our patients, but will only do so if I may appear under the assumed name of Dr. Doe.

4. Despite my position at , my limited involvement with abortions is not widely known. If I appear openly as a Plaintiff in this lawsuit, I am certain that the wide publicity accompanying that participation will cause me to be labelled the "Akron abortionist" by large parts of the public. I fear the following consequences on that publicity and that labelling:

a. A loss of reputation and a loss of income with to my primary role as an obstetrician and gynecologist in an active private practice. I base these expected losses in part on an experience of a colleague who lost a patient when the patient learned that the physician on occasion performed first trimester abortions.

b. A significant interference with my ability to continue in the development of a newly established education program at
College of Medicine, where I am on the faculty as a clinical assistant professor. That interference would occur because of the sensitivity of such government-funded programs to controversy.

c. Physical and psychological harm to my children, ages , and . Besides psychological harm coming, for example, from taunts from other children, I have recently developed a real fear about the possibility of physical harm, particularly given the high level of emotion in the Akron area.

d. Fear for my own personal safety. I have already been the victim of one unprovoked physical attack because of my presently little known involvement with abortions.

I am the real party in this action and assume the name of Dr. Doe in order to preserve my anonymity.

I say nothing further.

[SEAL]

STATE OF OHIO:
SUMMIT COUNTY:

personally appeared before me this 14th day of April, 1978 and upon oath states that the foregoing is true to the best of his knowledge.

/s/ Patricia A. Vance
Notary Public

SEALED AFFIDAVIT OF LINDA LOE TO PROCEED BY PSEUDONYM WITH DELETIONS

[Logged: May 3, 1978]

American Civil Liberties Union of Ohio

SEALED **TRUE NAME AFFIDAVIT OF LINDA LOE**

FOR THE COURT'S EYES *ONLY*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

STATE OF OHIO
COUNTY OF SUMMIT

Before Judge Contie

AFFIDAVIT OF LINDA LOE

I, being duly sworn, depose and say:

1. I am the woman identified by the pseudonym Linda Loe.

2. I reside at , Akron, Ohio. I am twenty-three years of age. I am the mother of children. I am unmarried. I support myself and my children with money from Aid to Families with Dependent Children.

3. I am presently in the tenth week of pregnancy. I desire to terminate this pregnancy because I do not have the money, nor the physical or emotional strength, to raise any additional children. I presently have an appointment to have my pregnancy terminated at Clinic on , May , 1978.

4. I wish to be a plaintiff in this lawsuit to assert my constitutional rights, and the rights of all women, pregnant now and in the future, who wish to terminate their pregnancies within the City of Akron.

5. I wish to proceed anonymously because of the humiliation which revealing my identity would cause me. If my name were in the newspapers, I would be extremely upset, because I do not want anyone to know about my private sexual matters. My parents, who live in Akron, would also be very upset if they learned that I was having an abortion. They are extremely religious, and have often told me that they do not approve of abortion, because of their religious and personal views.

I say nothing further.

Sworn to and subscribed before me this 3rd day of May, 1978 at Akron, Ohio.

/s/ Wayne G. Hawley
Notary Public
My commission has no expiration date.

ORDER DENYING MOTION OF PLAINTIFF TO ALLOW DR. DOE TO PROCEED UNDER SUCH PSEUDONYM

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: April 27, 1978]

DR. DOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ORDER

Plaintiffs have moved the Court to retain the true name affidavit of plaintiff Dr. Doe, a pseudonym, under seal and to allow Dr. Doe to proceed in this action under such pseudonym. Upon consideration and for the reasons set forth below, the instant motion shall be denied.

This action was initiated to test the constitutionality of Ordinance No. 160-1978 which amended and supplemented the Codified Ordinances of the City of Akron 1975, by the amendment of Chapter 1870, entitled "Regulation of Abortions." The plaintiffs are a doctor

under the fictitious name of Dr. Doe and three outpatient clinics. The named defendants consist of the City of Akron and three of its officials alleged to be responsible for the administration and enforcement of Ordinance No. 160-1978. Declaratory and injunctive relief is sought. The jurisdiction of the Court is invoked under 28 U.S.C. §§ 1331 and 1343.

In the complaint herein, Dr. Doe is described as a physician licensed to practice medicine in the State of Ohio, specializing in obstetrics and gynecology, who now performs, and in the future intends to perform, abortions within the City of Akron. Dr. Doe seeks to bring this action as a class action on his own behalf and on behalf of all physicians similarly situated.

By the instant motion, Dr. Doe raises the issue of his right to appear and proceed anonymously as a party plaintiff and potential class representative. In support of the motion, Dr. Doe states in an affidavit that revelation of his identity would cause severe personal, professional, and economic consequences.

No provision in federal law according a plaintiff the right to prosecute an action under a fictitious name has come to the attention of the Court. Rather, Rule 10(a), Federal Rules of Civil Procedure, provides, in pertinent part, that the title of the action in the complaint shall include the names of all parties. Despite said provision, individuals have been permitted in certain cases to sue under fictitious names. However, such is clearly an exception and privilege.

Lawsuits are matters of public record and the public has a recognized and valid interest in knowing the facts, including the identity of the parties. This is especially true in a lawsuit, such as the case at bar, wherein an ordinance or local law assertedly affecting the rights of

residents of a community is subject to a constitutional challenge. Thus as a matter of public policy, the Court deems it inappropriate to conceal the identity of parties except in the most unusual case. Such view has previously been expressed as follows:

> The privilege of using fictitious names in actions should be granted only in rare cases where the nature of the issue litigated and the interest of the parties demand it and no harm can be done to the public interest.

Roe v. State of New York, 49 F.R.D. 279, 282 (S.D. N.Y. 1970), quoting, *Buxton v. Ullman*, 147 Conn. 48, 156 A.2d 508 (1959).

Under the circumstances herein presented, the Court finds that as to Dr. Doe this is not such an unusual or exceptional case. His private or personal matters are not in issue or subject to scrutiny in this action. Rather, this action relates solely to professional and economic concerns. Essentially, Dr. Doe seeks a determination of the legality of freely chosen future conduct in the exercise of his profession. In view thereof, the Court finds no sufficient reason to disregard the public interest in a policy of full disclosure. Thus, the Court shall not permit Dr. Doe to proceed anonymously in this action.

Said conclusion finds additional support in the fact that Dr. Doe seeks to bring this action as a class action. It is well established that a determination of the adequacy of the proposed class representative is necessary to class certification. Thus the identity of Dr. Doe is relevant and material to the further prosecution of this action in its present posture.

Accordingly, the instant motion is hereby denied and the true name and address of Dr. Doe shall be designated in the caption of the complaint if he desires to proceed

in this action. Further, plaintiffs are hereby granted five (5) days leave from the date of this Order to amend their complaint in accordance herewith.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

ORDER DENYING MOTION OF PLAINTIFF TO ALLOW LINDA LOE TO PROCEED UNDER SUCH PSEUDONYM

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 3, 1978]

LINDA LOE, *ETC., ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ORDER

Plaintiffs have filed an amended complaint in this action. Upon consideration and for the reasons stated below, said complaint shall be stricken.

In their amended complaint, plaintiffs have omitted Dr. Doe and substituted Linda Loe for him as a party plaintiff. Such is a pseudonym and the allegations of said complaint describe plaintiff Loe as a pregnant woman who is presently seeking an abortion in the City of Akron, Ohio. She assertedly seeks to bring this action in her own behalf and on behalf of a class which includes

all women who are now or may in the future become pregnant and seek an abortion in Akron.

At the hearing, held April 27, 1978, on plaintiffs' motion for a temporary restraining order, the Court unequivocably stated that no parties shall be permitted to proceed anonymously in the within action. In view thereof and of the Court's Order of said date, the amended complaint shall be stricken and the true name and address of Linda Loe shall be designated in the caption of the complaint if she desires to proceed in this action. Plaintiffs shall be granted leave to amend their complaint on or before May 8, 1978 at 9:00 a.m.

Should plaintiffs' second amended complaint assert class allegations, they shall move for class certification on or before May 12, 1978. Defendants shall respond thereto on or before May 18, 1978. Such schedule is necessitated by the final hearing date set herein upon agreement of counsel and the delays prompted by the uncertain posture of plaintiffs' action. If further delays render the schedule more burdensome, the Court may consider other appropriate action.

Accordingly, the amended complaint is hereby stricken, and the true name and address of Linda Loe shall be designated in the caption of the complaint if she desires to proceed in this action. Plaintiffs are hereby granted leave to amend their complaint in accordance herewith on or before May 8, 1978 at 9:00 a.m. No further amendments shall be permitted without leave of Court. Further, if plaintiffs seek to assert a class action, they shall move for class certification on or before May 12, 1978, and defendants shall respond thereto on or before May 18, 1978.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

MOTION TO RECONSIDER
WITH AFFIDAVITS OF NORMA GOLDBERGER AND KATHY GOTSHALL

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 4, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION FOR RECONSIDERATION

Plaintiffs hereby move this Honorable Court to reconsider its order of May 3, 1978, striking plaintiffs' First Amended Complaint. This motion to reconsider is made for the reasons more fully set forth in the brief and affidavits attached hereto and incorporated herein by reference. Plaintiffs further move this Honorable Court to permit Linda Loe (pseudonym) to continue in this case under pseudonym pursuant to plaintiffs' previous motion with regard thereto.

Respectfully submitted,

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

BRIEF IN SUPPORT OF MOTION TO RECONSIDER

Plaintiffs bring this motion in the hope of presenting to this Court adequate reason for an order granting Linda

Loe leave to proceed by pseudonym. Plaintiffs at the outset recognize the discretionary nature of an order granting such leave. They also appreciate the strong public interest in having lawsuits prosecuted in the real names of the parties involved.

In the present action the three clinic plaintiffs appear without pseudonym. They make no request that they be in any way shielded from public scrutiny. However, Linda Loe faces a very different situation and therefore moves that this Court exercise its discretion and grant her leave to proceed by pseudonym.

Linda Loe makes her request for two reasons. First, many citizens of Akron, Ohio, have had a strong emotional reaction to the debate over the propriety of abortion. Unfortunately, the debate has sparked social strike. Manifestations of this strife have included regular public demonstrations directed against the clinic plaintiffs (see Goldberger Affidavit paragraph 2; Gotshall Affidavit paragraph 2), threatening and harassing telephone calls made to the clinic plaintiffs and their employees (see Goldberger Affidavit paragraphs 3 and 4; Gotshall Affidavit paragraph 3), threatening and harassing letters sent to the clinic plaintiffs and their employees (see Goldberger Affidavit paragraph 5; Gotshall Affidavit paragraph 4) and an act of arson directed against one of the clinic plaintiffs (see Goldberger Affidavit paragraph 6).

The clinic plaintiffs can and have taken precautions adequate to deal with these serious problems (see Goldberger Affidavit paragraph 7; Gotshall Affidavit paragraph 5). Linda Loe does not have the requisite funds or assistance to take the precautions necessary to safeguard herself or her family from threats, harassment or acts of physical violence. Should she be compelled to

make her true name and address known in this litigation there is a substantial likelihood that she or her family will suffer physical or psychic harm at the hands of the misguided minority who have already victimized the clinic plaintiffs and their employees. The real possibility of injury to Linda Loe and her family marks this action as one in which an application for leave to proceed by pseudonym may appropriately be granted without undermining the strong public interests previously discussed.

The second reason for Linda Loe's request concerns the nature of the subject matter of this action. Linda Loe's claim is such that she must make public disclosure of some of the most intimate details of her personal life. This disclosure could be extremely harmful to Linda Loe if she were to proceed in her real name. While it might be argued that this is an obligation assumed by every litigant before a United States District Court, exceptions to the real name rule have been recognized in circumstances precisely like those in the present case. In the precedent setting case of *Roe v. Wade*, 410 U.S. 113 (1973), the propriety of litigation by pseudonym in the case of a pregnant woman was sustained. The same result obtained in *Coe v. Gerstein*, 376 F. Supp. 695 (S.D. Fla. 1973), and in a number of other decisions.

Linda Loe recognizes the burden her request casts upon the Court. The request to proceed by pseudonym is not made lightly or frivolously but in the serious and earnest belief that relief is warranted under the special circumstances of this case. Plaintiffs believe that no harm will be done to the public interest if Linda Loe's request is granted. They also believe that Linda Loe's request presents separate and distinct issues from those that may arise when application is made for class action certification. For the previously enumerated reasons

plaintiffs respectfully request that this Court grant plaintiff's motion to reconsider and allow Linda Loe to proceed by pseudonym.

Respectfully submitted,

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaitniffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

CERTIFICATE OF SERVICE

A copy of the foregoing Brief In Support Of Motion To Reconsider was mailed this 4th day of May, 1978, to James L. Bickett, 304 Municipal Building, Akron, Ohio 44308, and to David G. Umbaugh, 40 E. Mill Street (at Main), Akron, Ohio 44308.

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR
REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

AFFIDAVIT

NORMA GOLDBERGER, being duly sworn, deposes and says:

1. I am president and clinic coordinator of Akron Women's Clinic, Inc. (hereinafter AWC) an Ohio Corporation. AWC operates a family planning clinic which provides abortion services at 513 West Market Street, Akron, Ohio 44303.

2. AWC has been the target of public demonstrations on a regular basis (once per week) since its opening on December 19, 1976. The number of demonstrators has varied from 1 to approximately 30. The subject of these demonstrations has always been the propriety of abortions. On occasion the demonstrators have been rowdy and/or threatening in their behavior. They have taunted AWC patients coming into and going out of the clinic.

3. The telephones at AWC have been subject to "jamming" on a regular basis. During such "jamming" the telephone lines are repeatedly occupied by callers who will not speak or hang up.

4. At my home I received a telephone call which threatened the life of my child and linked the threat to the abortion issue.

5. AWC and I have received a number of threatening letters. These letters linked the threats to the abortion issue. One of the letters contained highly offensive anti-semitic remarks. Another of the letters contained a newspaper report describing a case of suspected arson at AWC. This letter also contained the comment "there will be more".

6. In early March of 1978 there was a fire at AWC. Special Fire Investigator Finney indicated to me his belief that this fire was arson. The fire was set in a bathroom at AWC. The fire was started by the ignition of two rolls of toilet paper. Upon information and belief the fire was arson. This fire forced the evacuation of AWC and did property damage.

7. Because of the demonstrations; threatening and "jamming" telephone calls; threatening letters and act of arson committed on AWC premises I have deemed it essential to increase security precautions including the installation of stainless steel mesh over all windows, the introduction of a burglar alarm, the introduction of smoke detectors, the positioning of a receptionist in the front room of AWC at all times, and the making of arrangements to insure the physical protection of AWC and its occupants.

NORMA GOLDBERGER

SWORN TO, BEFORE ME, this 4th day of May, 1978, at Akron, Ohio.

Notary Public

[SEAL]
STATE OF OHIO
COUNTY OF SUMMIT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

AFFIDAVIT

KATHY GOTSHALL, being duly sworn, deposes and says:

1. I am executive director of Akron Center for Reproductive Health, Inc. (hereinafter ACRH) an Ohio corporation. ACRH operates a family planning clinic

which provides abortion services at 839 East Market Street, Akron, Ohio 44305.

2. ACRH has been the target of public demonstrations on a regular basis (once per week) in the year since its opening. The number of demonstrators has varied from approximately 5 to 15. The subject of these demonstrations has always been the propriety of abortions.

3. Because of a number of threatening, harassing and obscene telephone calls I have had to change my home telephone number from a listed number to an unlisted number. The person or persons making these telephone calls adverted to my connection with ACRH and the abortion issue during these calls.

4. ACRH and I have received approximately five harassing letters in the last year concerning the topic of abortion. These letters have included accusations that my staff and I are "murderers."

5. Because of the demonstrations; threatening, harassing and obscene telephone calls; threatening letters; and incidents of arson against abortion clinics in Akron, Ohio and Cleveland, Ohio I have deemed it essential to increase security precautions at ACRH. Newly introduced precautions include the hiring of a security guard, the introduction of dead bolt locks, the purchase of fire extinguishers and the introduction of a burglar alarm system.

KATHY GOTSHALL

SWORN TO, BEFORE ME, this 4th day of May, 1978, at Akron, Ohio.

Notary Public

[SEAL]

STATE OF OHIO
COUNTY OF SUMMIT

ORDER DENYING MOTION OF PLAINTIFFS TO RECONSIDER

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 5, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

ORDER

Plaintiffs have moved the Court to reconsider its Order of May 3, 1978 striking their First Amended Complaint.

Upon consideration, the instant motion is hereby denied.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

PLAINTIFFS' FOURTH AMENDED COMPLAINT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC.
839 East Market Street
Akron, Ohio 44305

and

AKRON WOMEN'S CLINIC, INC.
513 West Market Street
Akron, Ohio 44303

and

WOMENCARE, INC.
759 West Market Street
Akron, Ohio 44303

and

DR. ROBERT BLISS
411 Oak Street
Cincinnati, Ohio

Plaintiffs

v.

CITY OF AKRON
166 South High Street
Akron, Ohio 44308

and

JOHN S. BALLARD, Mayor
166 South High Street
Akron, Ohio 44308
Individually and in His Official Capacity

and

DR. C. WILLIAM KECK
Director of Public Health
177 South Broadway
Akron, Ohio 44308
Individually and in His Official Capacity

and

PETER OLDHAM, Police Prosecutor
217 South High Street
Akron, Ohio 44308
Individually and in His Official Capacity
Defendants

Before Judge Contie

FOURTH AMENDED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND OTHER RELIEF

I. Nature of the Action

1. This is a civil rights action brought under 42 U.S.C. Section 1983 and the United States Constitution by a Physician and by three out-patient clinics which provide services and facilities for the performance of abortions in the City of Akron, asserting the rights of themselves and of their patients, against the City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978, which amended and supplemented the Codified Ordinances of the City of Akron, 1975, by the amendment of Chapter 1870,

entitled "Regulation of Abortions" (a copy of Ordinance No. 160-1978 is attached as Exhibit A to the original Complaint herein; said ordinance will hereinafter be referred to as "Chapter 1870"). Plaintiffs seek declaratory and injunctive relief. The basis of the action is that Chapter 1870 violates rights guaranteed by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution.

II. Jurisdiction

2. This Court has jurisdiction of this action by virtue of 28 U.S.C. Section 1343(3) and 1343(4), authorizing jurisdiction of claims brought under 42 U.S.C. Section 1983 to enforce rights guaranteed by the United States Constitution. This Court also has jurisdiction of this action pursuant to 28 U.S.C. Section 1331 as the claims arise under the United States Constitution and the matter in controversy exceeds $10,000.00, excluding costs and interest. This action also seeks declaratory judgment pursuant to 28 U.S.C. Section 2201 and 2202.

III. Parties

3. Plaintiffs Akron Center for Reproductive Health, Inc., Akron Women's Clinic, Inc., and WomenCare, Inc. ("plaintiff clinics") are Ohio corporations which provide family planning services in the City of Akron, including the provision of out-patient facilities for the termination of pregnancies through abortions. On or after May 1, 1978, plaintiffs face a loss of income and a deprivation of their constitutional rights should they comply with Chapter 1870, and a threat of criminal prosecution if they do not. Plaintiffs assert not only their own rights, but those of their patients as well.

4. Dr. Robert Bliss is a physician licensed to practice medicine in the State of Ohio who has performed, and

will perform, abortion procedures within the City of Akron. Dr. Bliss faces a loss of income and deprivation of constitutional rights if he complies with Chapter 1870, and a threat of criminal prosecution if he does not. Dr. Bliss asserts his own rights and those of his patients as well.

5. Defendant City of Akron is the Ohio municipality whose agents and officers enacted and will enforce, on its behalf, Chapter 1870.

6. Defendant John S. Ballard is the Mayor of the City of Akron and as its chief executive officer has primary responsibility for the execution of its laws, including Chapter 1870. He is named herein in his individual and official capacities.

7. Defendant Peter Oldham is the Police Prosecutor of the City of Akron and as such is responsible for prosecuting, on behalf of the City, violations of its laws, including Chapter 1870. He is named herein in his individual and official capacities.

8. Defendant Dr. C. William Keck is the Director of Public Health of the City of Akron and as such is charged with the duty to administer certain provisions of Chapter 1870, including those involving inspections and reporting. He is named herein in his individual and official capacities.

9. At all times relevant herein defendants have acted, and will act, under color of state law.

IV. Factual Allegations

10. Chapter 1870 was passed by a seven to six vote of the Akron City Council on February 28, 1978, and became law ten days thereafter. Section 3 thereof provides that it shall take effect and be in force as of May 1, 1978.

11. Chapter 1870 is the only legislation of the City of Akron which regulates a surgical procedure.

12. Upon information and belief defendants will seek plaintiffs' compliance with the provisions of Chapter 1870 and will cause criminal prosecutions to be instituted against plaintiffs for failure to comply. On April 4, 1978, counsel for plaintiffs requested assurance from defendant Ballard that the enforcement of sections of Chapter 1870 would be stayed pending an adjudication of their constitutionality (a copy of the correspondence transmitting that request is attached as Exhibit B to the original complaint herein). Defendants have provided no such assurance.

13. Compliance with Chapter 1870 will cause irreparable injury, for which no adequate remedy at law exists, to plaintiffs and to their patients, by depriving them of rights guaranteed under the Constitution and by increasing the physical and emotional risk attendant to the making and effectuation of the choice whether to carry a pregnancy to term or to end it by abortion. Furthermore, failure to comply with Chapter 1870 will cause plaintiffs to face criminal prosecution.

14. Plaintiffs also face significant economic harm should Chapter 1870 becomes effective, because it will discourage a large number of women from choosing to terminate their pregnancies in the City of Akron.

V. First Cause of Action (Substantive Due Process)

15. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 14.

16. Chapter 1870 deprives plaintiffs and their patients of the following liberties without due process of law,

in violation of the Fourteenth Amendment to the United States Constitution:

a. The right of their patients to make and effectuate the decision to terminate their pregnancy, a fundamental right of privacy guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution; see *Roe v. Wade*, 410 U.S. 133, 152-153 (1973).

b. The right of a physician to practice medicine in accordance with his or her best medical judgment, a right guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

c. The right of a physician to give, and of patients to receive, medical treatment and advice, in accordance with accepted medical standards, pertaining to the decision whether to terminate a pregnancy, rights guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

d. The rights of the plaintiff clinics to provide and their patients to receive counselling, education and other services relevant to the making and effectuation of the abortion decision, rights guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

VI. Second Cause of Action (Equal Protection)

17. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 16.

18. Chapter 1870 deprives plaintiffs and their patients of equal protection of the laws, in violation of the

Fourteenth Amendment to the United States Constitution, because it unreasonably singles out for regulation the abortion procedure, while all other comparable medical procedures are left unregulated.

VII. Third Cause of Action (Free Exercise and Establishment

19. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 18.

20. Chapter 1870 violates the prohibitions of the First Amendment against laws respecting the establishment of religion and interfering with the free exercise thereof, for the following reasons:

a. The purpose and effect of Chapter 1870 is to impede and/or prevent pregnant women from obtaining abortions.

b. Chapter 1870 constitutes enactment into law of one religious belief concerning abortions and the nature of the fetus, and constitutes the imposition of that religious view on women who would otherwise choose abortion in accordance with their religious or non-religious beliefs.

c. Chapter 1870 has no secular justification.

d. The enactment of this religious view into law has created and threatened further entanglement of Church and State and fosters political divisions along religious lines.

e. Chapter 1870 discourages, impedes, and/or prevents women from obtaining safe, legal abortions in accordance with the different teachings of the religions to which they adhere and/or with the dictates of their conscience.

f. Chapter 1870 forces physicians, under the threat of criminal penalties, to endorse and communicate to their patients one religious view regarding human life.

VIII. Reservation of Rights

20. Plaintiffs are asking leave of this Court to file this Fourth Amended Complaint. Previous amended complaints were filed pursuant to the Orders of this Court entered on April 27, 1978, May 3, 1978, and May 5, 1978. (All of which orders are hereby incorporated herein by reference). Said orders forbade certain persons, more fully described in the Orders, from proceeding in this action by fictitious name. Pursuant to this Court's Orders these persons have been stricken from this complaint. However, any and all rights to appeal the above enumerated Orders are hereby reserved.

IX. Prayer

WHEREFORE plaintiffs pray that this Court:

1) assume jurisdiction of this action;

2) issue a temporary restraining order, a preliminary injunction, and a permanent injunction restraining defendants and their employees, agents, and servants from enforcing Chapter 1870;

3) declare that Chapter 1870 violates the Constitution of the United States, as more fully set forth in plaintiffs' three Causes of Action;

4) award plaintiffs their costs and attorneys' fees, pursuant to 42 U.S.C. Section 1988; and

5) enter such other and further relief as the Court deems just and proper.

(By) /s/ Wayne G. Hawley

Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Ellen Leitzer
Janet Benshoof
American Civil Liberties Union
Reproductive Freedom Project
22 East 40th Street
New York, New York 10016
(212) 725-1222

Robert P. App
American Civil Liberties Union
of Ohio Foundation, Inc.
203 East Broad Street
Columbus, Ohio 43215
(614) 228-8951

Patricia A. Vance
34 North Hawkins Avenue
Akron, Ohio 44312
(216) 836-9358

Dennis Haines
Patricia S. Roberts
4th Floor, Dollar Bank Building
Post Office Box 849
Youngstown, Ohio 44501
(216) 743-5101

Wayne G. Hawley
American Civil Liberties Union
of Cleveland, Inc.
2108 Payne Avenue, Suite 507
Cleveland, Ohio 44114
(216) 781-6276

Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

CERTIFICATION

A copy of the foregoing Plaintiffs' Motion to File a Fourth Amended Complaint and of the supporting Memorandum and proposed Fourth Amended Complaint attached thereto was mailed on the 17th day of July, 1978, to James L. Bickett, Assistant Law Director, 304 Municipal Building, Akron, Ohio 44308, and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio 44308.

/s/ Wayne G. Hawley

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: July 17, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

PLAINTIFFS' MOTION FOR THE SETTING OF A DATE CERTAIN

Plaintiffs respectfully move this Court to set a date certain for the hearing to be held in the above-captioned matter. Because of the large number of expert witnesses involved in this action, significant advance notice of the precise date of hearing is essential and will serve the interests of justice.

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil
Liberties Union of Ohio
Foundation, Inc.

PROOF OF SERVICE

A copy of the foregoing Plaintiffs' Motion for the Setting of A Date Certain was sent to James L. Bickett, 304 Municipal Builing, Akron, Ohio, 44308, and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio, 44308, by ordinary U.S. mail this 17th day of July, 1978.

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil
Liberties Union of Ohio
Foundation, Inc.

DEFENDANTS' ANSWER TO FOURTH AMENDED COMPLAINT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: August 7, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ANSWER OF DEFENDANTS, CITY OF AKRON, JOHN S. BALLARD, DR. C. WILLIAM KECK, AND PETER OLDHAM

Now come Defendants, City of Akron, John S. Ballard, Dr. C. William Keck, and Peter Oldham, and for their answer to Plaintiff's Fourth Amended Complaint state as follows:

First Defense

1. Plaintiffs fail to state a claim upon which relief can be granted.

Second Defense

2. Plaintiffs Akron Center for Reproductive Health, Inc., Akron Women's Clinic, Inc., and Womencare, Inc., lack standing to assert the rights of their patients and physicians against The City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978 as alleged in Paragraphs 1 and 3 of the Fourth Amended Complaint. Plaintiff, Dr. Robert Bliss, lacks standing to bring this action against The City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978, as alleged in Paragraphs 1 and 4 of the Fourth Amended Complaint.

Third Defense

3. Defendants admit that the statutes set forth in Paragraph 2 of the Plaintiffs' Complaint confer jurisdiction on this Court, but deny that the statements and allegations as set forth in said Complaint state claims within the statutory jurisdiction of the Court.

Fourth Defense

4. Defendants are without knowledge or information sufficiant to form a belief as to the truth of Paragraphs 3 and 4 of the Fourth Amended Complaint, but deny that Plaintiffs face a deprivation of constitutional rights should they comply with Chapter 1870.

5. Defendants admit Paragraphs 5, 6, 7, 8 and 9 of the Fourth Amended Complaint, but deny that the individual Defendants were properly named in their individual capacities.

6. Defendants admit Paragraph 10 of the Fourth Amended Complaint.

7. Defendants deny Paragraph 11 of the Fourth Amended Complaint.

8. Defendants admit that Plaintiffs will face prosecution for failure to comply with the provisions of Chapter 1870 as alleged in Paragraphs 12 and 13, but deny each and every other allegation contained in Paragraph 13 of the Fourth Amended Complaint.

9. Defendants deny that Plaintiffs face significant economic harm should Chapter 1870 become effective as set out in Paragraph 14 of the Fourth Amended Complaint. Defendants are without knowledge or information sufficient to form a belief as to whether Chapter 1870 will discourage a large number of women from choosing to terminate their pregnancies in the City of Akron.

10. Defendants deny Paragraph 15 of the Fourth Amended Complaint not specifically admitted herein.

11. Defendants deny Paragraph 16 of the Fourth Amended Complaint.

12. Defendants deny Paragraph 17 of the Fourth Amended Complaint not specifically admitted herein.

13. Defendants deny Paragraph 18 of the Fourth Amended Complaint.

14. Defendants deny Paragraph 19 of the Fourth Amended Complaint not specifically admitted herein.

15. Defendants deny both paragraphs numbered 20 of the Fourth Amended Complaint.

WHEREFORE, Defendants pray that the Court:

(a) Dismiss Plaintiffs' Fourth Amended Complaint;

(b) Dissolve the temporary restraining order previously issued by the Court in this action on April 27, 1978;

(c) Declare that Chapter 1870 does not violate the Constitution of the United States;

(d) Should the Court find that some sections of Chapter 1870 violate the Constitution of the United States, that the Court sever the unconstitutional sections from the constitutional sections and uphold Defendants' rights to enforce the constitutional sections of Chapter 1870;

(e) Deny Plaintiffs' request for costs and attorneys' fees; and

(f) Award Defendants their costs and attorneys' fees.

Respectfully submitted,

John E. Holcomb
Director of Law
The City of Akron

/s/ James L. Bickett
Assistant Director of Law
304 Municipal Builing
Akron, Ohio 44308
(216) 375-2034

/s/ Victor A. Dandrea
Assistant Director of Law

CERTIFICATION

A copy of the foregoing Answers was sent this 7th day of August, 1978, by regular mail, to Wayne G. Hawley, Attorney for Plaintiff, American Civil Liberties Union of Cleveland, Inc., 1223 West Sixth Street, Second Floor, Cleveland, Ohio 44113; to Stephan A. Landsman,

Attorney for Plaintiff, Cleveland Marshall College of Law, Cleveland State University, Cleveland, Ohio 44115; and to David G. Umbaugh, Attorney for Intervenors, 40 East Mill Street, Akron, Ohio 44308.

/s/ James L. Bickett
Assistant Director of Law
Attorney for Defendants

TRANSCRIPT EXCERPTS OF DR. ROBERT DALE CRIST

VOLUME I

[*Direct Examination by Mr. Landsman:*]

[24] Q. Are you currently licensed in any states, Doctor?

A. I am licensed in Kansas and Missouri.

Q. Are you Board certified in any specialty, Doctor?

A. I am Board certified in obstetrics and gynecology.

Q. Do you hold any degrees besides the M.D. degree?

A. Yes. I completed a Ph.D. in biochemistry.

Q. What was your military service in the medical context?

A. I spent approximately three years serving as Assistant Chief of Obstetrics and Gynecology and Research Coordinator at Walter Reed Army Medical Center in Washington, D.C.

Q. At that time, did you have any experience with the abortion issue?

A. Yes, it was approximately January of 1969 that a final directive came from the Department of Defense requesting that military regulations governing abortion and sterilization be updated to meet civilian standards.

As Assistant Chief, I was assigned the duty of working on that regulation.

Q. Doctor, do you have any publications?

A. In excess of 20 in the basic science and clinical area of obstetrics and gynecology.

Q. Have you done any consulting work, Doctor?

A. Yes, within the relevant field I have been a [25] consultant for the Upjohn Company in development of

prostaglandins in both induction of a term labor and abortion.

I have been a consultant to several other drug firms on Level 3 trials or Phase 3 trials of drugs, as well as a consultant to the March of Dimes.

Q. Doctor, have you ever consulted on teenage sexuality questions?

A. Yes. I am currently a member of a five-membered committee, appointed from the American College of Obstetrics and Gynecologists as a task force on adolescent pregnancy.

Q. What is your present position, Doctor; what is your employment?

A. I am a full-time member of the faculty at the University of Kansas, School of Medicine, where I carry a rank of Associate Professor in Obstetrics and Gynecology, and Assistant Professor of Biochemistry.

* * *

[28] Q. What are the relevant medical procedures for inducing abortion, Doctor?

A. Well, the relevant procedures really depend to some extent upon the stage of gestation.

For example, in a very early pregnancy, a procedure called menstrual regulation or menstrual extraction has been commonly employed.

This amounts to using a small, flexible tube and applying suction supplied either with a mechanical aspirator, a syringe or other suction device, and removing the products of the pregnancy.

[29] This applies up to about four weeks from the point of conception.

* * *

Classically, from about the 14th week until the 17th or 18th week has been described a gray zone. This is a zone in which technically performance of abortion was found difficult, and in the very early days was found to carry increased risk.

Following the gray zone, the classic approaches were [30] amniocentesis or placing a needle through the abdominal wall and into the fluid sack surrounding the pregnancy, removing part of that fluid and injecting either irritating dyes—the principal one called Rivinol—or Picric acid derivative imported from Japan, or hypertonic solutions, including hypertonic saline, urea and dextrose, and natural occurring products called prostaglandins.

All of these accomplished abortion by inducing labor.

More recent technical additions have gotten rid of the gray zone. These have been characterized as dilatation and evacuation or D and E, as it is commonly referred to.

* * *

[33] Q. In your practice, Doctor, do you use those procedures that you have described in the weeks you described them?

A. No, not totally. I carry the D and E procedure to approximately 21 weeks after the last menstrual period.

Rather than using a labor-inducing dose of urea after the 21st week, I use a combination of laminaria to dilate the mouth of the womb of the cervix, injection of urea overnight to soften the tissues and use a D and E procedure the following morning.

These I carry fairly routinely to 24 weeks, and in extreme medical conditions well past that point.

* * *

[35] Q. As a summary in terms of mortality, which is safer in terms of maternal health, pregnancy or abortion, by [36] comparatives?

A. Using first trimester legal abortion statistics, it is from eight to 35 times safer than is pregnancy to term and childbirth.

Q. Could you compare for us, Doctor, mortality experienced in the abortion context with mortality experienced in other medical or surgical procedures?

A. Yes. I think that is an interesting comparison.

For instance, in public health hospitals in the United States in 1969, this was 1281 hospitals involving over four million surgical procedures in ranging the number of procedures done; Procedure No. 21 was surgical removal of a tooth, where the incidence of death was 5.4 per 10,000 or 54 per 100,000.

Simple extraction of a tooth, because of decreased precautions and medical safety standards, carried an incidence of death of 174 per 100,000 procedures.

Let's take a very common situation, a penicillin shot given in a physician's office. This carries roughly the same mortality risk as a first trimester legal abortion, roughly 1.4 to two per 100,000 patients receiving penicillin injections.

* * *

[37] Q. Now, returning to that question, though, of the applications here in Akron.

A. There is no reason to believe that the medical community in Akron is any less skilled in providing medical services than the rest of the country.

In fact, I spent a good part of yesterday afternoon reviewing the records and going through a clinic providing first trimester abortion services in Akron.

In reviewing their records, it appears that their safety is even better than the 1.2 per 100,000.

Q. Thank you, Doctor. If you would reiterate, Doctor, [38] turning to second trimester abortions, which techniques are available for their effectuation? This is after the end of the first trimester pregnancy.

A. Still the most common technique used for second trimester is the injection, intra-amniotically of a hypertonic saline.

This is done roughly between the 18th and 24th week after the last menstrual period.

Of growing emphasis and obvious safety is the use of dilatation and evacuation, certainly through the 17th or 18th week after the last menstrual period.

This safety has been very nicely documented in publications from the physician group at the Communicable Disease Center, derived from their abortion surveillance statistics, comparing dilatation and evacuation with hypertonic saline and with the use of intra-amniotic prostaglandins.

Roughly from the end of the first trimester through the 20th week, the relative risk factors comparing dilatation and evacuation with, for instance, hypertonic saline, the risk factor is over two.

Comparing with prostaglandin intra-amniotically, that risk factor is 2.65.

* * *

[39] Q. Which do you rely on now?

A. I use the D and E procedures exclusively at this time, either with urea above 21 weeks or without urea prior to that.

Q. Was any distinction made between first and second trimester performance?

A. Yes. This distinction was made following publications by Dr. Tietze, based on statistics from surveys and statistics from studies in 1972 where he found the incidence of complications rising after the first trimester.

For this reason, with the importance of his position and the statistics he presented, there was a reluctance of a physician to try a procedure past the end of the first trimester, other than to delay and do an injection type labor induction termination.

[40] Q. What were the consequences of this distinction on the delivery of medical care?

A. The consequences were the creation of a gray zone where women seeking abortion services were delayed from 14 weeks until they reached 16 or 17 weeks.

Q. Where would those procedures be performed?

A. The injection procedures were done by and large in hospitals, based again upon Dr. Tietze's recommendation in his publication.

Q. Does this distinction remain valid between the first and second trimester, Doctor?

A. No, I think that distinction should be carried, rather than at the end of the first trimester, up to about 17 weeks.

Q. Why do you say that, Doctor?

A. Both from my own personal experience in performing roughly 12 to 15 hundred second trimester procedures per year, based upon statistics from the Communicable Disease Center, upon visiting at least five other clinics doing D and E procedures, and finally I think my view is supported by a recent decision of a New Jersey Medical Board to extend the right of outpatient clinics to do procedures to 17 weeks.

Q. Need early second trimester procedures, the ones you described, need they be performed in a hospital?

[41] A. No. In fact, my experience—and again supported by CDC statistics—the risks to the patient are less if the procedure is done in a free-standing clinic rather than in a hospital.

Q. Why is that, Doctor?

A. For one thing, most of the physicians working in free-standing clinics have extensive experience in performing vaginal abortion procedures.

While the less experienced physician will often use the hospital setting and general anesthesia to perform a second trimester procedure.

Secondly, physicians in training, residents, if you will, have their practices generally confined to the hospital setting and they are less experienced operators.

Many statistics will point out that they have an increased incidence of complications.

Q. Are early second trimester procedures being performed in clinical settings around the United States now?

A. Yes, they are. I know of several friends and associates who are doing them in New Mexico, in Texas, in Colorado, in California, in New Jersey, in Florida.

Q. Are they achieving the level of success that you have described previously?

A. Most of these statistics that the CDC has presented have been from five high-volume clinics doing second [42] trimester abortions.

One of those was the Hodari group in Detroit. Another is in Milwaukee; a third operates in Santa Fe and Dallas.

Q. In light of all these changes, at what date in gestation should pregnancy be required to be terminated in a hospital for medical reasons?

A. Well, in my estimation, I would place the requirement no earlier than the 17th or 18th week, and in the hands of very skilled operators who are in close proximity to a full-service hospital, I think that limit can be extended to perhaps as far as 20 weeks from the last menstrual period.

* * *

[43] Q. Doctor, is the Plaintiff, Akron Women's Clinic, adequately prepared to perform early second trimester abortions in a manner that will not increase risks to maternal health over equivalent risks in a hospital?

* * *

[44] ***The Witness:*** Yes. I visited the Akron Women's Clinic for three to three and a half hours yesterday and reviewed their records, their facilities, their equipment and found them fully adequate to perform second trimester abortions, in keeping with the standards prescribed by the American College of OB-GYN, and also those that we use within our own setting at the University of Kansas.

By Mr. Landsman:

Q. In your professional capacity, have you ever had occasion to review the quality of service delivered by any other abortion facility by examining it and going through it?

A. Yes. In 1972 the Kansas State Health Department was concerned after reports of unsafe conditions in a free-standing clinic in Kansas City, Kansas.

I was one of three physicians to examine that facility and make recommendations on its safety.

Q. Were your evaluations and recommendations accepted, Doctor?

A. Yes, they were, and the clinic instituted all of the recommendations that we offered.

The Court: The prior answer that you gave was that in many instances [45] a second trimester abortion can be performed more efficiently in a free-standing clinic than a hospital because the doctors are more skilled in many instances. They are doing a lot of this work; is that correct?

The Witness: That is correct.

The Court: How could you examine a clinic without checking the skill of the doctor and determine whether or not the clinic is qualified to perform second trimester abortions?

The Witness: I found that the facilities and equipment, resuscitative equipment, et cetera, necessary was present in the clinic.

I reviewed the records of the physicians and found that—

The Court: Assuming the skill.

The Witness: —that three of them had done extensive numbers of procedures and their operative morbidity and mortality was below that of published national standards.

I assume from that that they are skilled [46] operators.

The Court: Okay. Fine.

By Mr. Landsman:

Q. Doctor, what are the consequences to a woman if a second trimester procedure is not available in her community; health consequences?

A. This is a very common—has been a very common situation in the past, particularly in small rural areas.

The options open to the woman is to carry the pregnancy to term and deliver it, which increases her morbidity and mortality risk; to travel out of state where second trimester abortions can be performed, or to another neighboring community within the same state.

In those without money and unable to travel or secure second trimester abortions, they do resort to drastic means, such as self-abortion or criminal abortion.

Q. What are the health consequences of travel, if you travel outside your community to obtain a second trimester procedure?

A. There are several. There is a delay in obtaining those services. Usually there is a considerable period of time spent in searching, by telephone, by word of mouth, et cetera, as to where the procedure is available.

Secondly, one of the important parts of providing any surgical or medical service is follow-up of a patient.

[47] When she travels some distance, which may be as much as—I, for instance, receive patients from as far as 700 miles from Kansas City, and it is impossible for those patients to return to me for follow-up care.

In the rare instances of complications, physicians who are not experienced in following abortion patients and their difficulties afterwards often overreact and really overtreat the situation, and we see women who end up with hysterectomies, where simple administration of a medication to cause uterine contraction and antibiotics would have been fully adequate to treat her.

Q. What are the health consequences if she chooses that path which you described as most dangerous, illegal abortions or those that are self-induced?

A. Let's look, for instance, again at a few statistics.

If we compare survey statistics from 1969 and '70, there was a death rate from abortion of roughly 79 per 100,000 abortions performed.

Admittedly, those are survey estimates, compared with estimates today from 1.2 to 2.3 if we include the full range of first and second trimester terminations.

* * *

[59] Q. What is your general attitude toward parental notification and/or the involvement of parents in this question of teenage pregnancy?

A. I certainly feel that parental involvement is very, very important.

Number one, after an emotionally traumatic decision such as seeking an abortion and undergoing an abortion [60] procedure, most women, adolescents particularly, need a lot of core support. They need their family rallied behind them to say, "No, you did not do a bad thing. No, we love you. We support you. We are going to help you grow and mature through this experience."

For that reason, I think it is very important that the adolescent's parents be involved in her decision-making and be involved in the decision to have an abortion and the aftermath of it.

Q. Do you ever have adolescents who do not want to have their parents involved in this decision?

A. That is a very common situation for adolescents.

We have sort of a general observation that the younger the adolescent, the more advanced her pregnancy will be at the time she seeks abortion or prenatal services.

It is difficult for the adolescent to admit that she is a sexual being and that she might be pregnant.

It is only after a lengthy period of time that she will seek some outside help.

The last group that she wants to know about her sexuality are her parents, who have told her that this is not a thing that nice young girls do.

Now, there are other extremes where I feel that informing the adolescent's parents should not be done.

[61] Q. Well, before we get there, Doctor, what do you do with that young woman who comes in and says, "I don't want my parents to be notified"?

A. Well, first of all, the counselor, who is extensively experienced in dealing with these young women spends time exploring why she does not want her parents informed, why she does not want them involved.

Generally, her counseling session with them is able to convince them that it would be for their betterment, both today and in the future, to involve the parents in the decision.

If she is unsuccessful at that, then I spend time and we really try to convince the girl.

If there is still ambivalence on the situation, I have even suggested that we delay the procedure for one day and we go find the parents and bring them in and discuss it with them as a group.

Q. Now, the other side of the coin, Doctor, are there ever occasions where the young woman finally refuses to have her parents informed?

A. Yes, there are numerous instances of that.

Q. What do you do when that has taken place?

A. I generally perform the abortion.

Q. With or without notification?

A. Without notification or consent of the parents.

[62] A. Why, Doctor?

A. I feel that in my judgment as a physician, the welfare of that patient is my number one concern, and her welfare may be jeopardized, or in some instances would be jeopardized, in my estimation, by involvement of the parents in the abortion.

Q. In your professional opinion and in your experience, would it ever pose a physical threat to the pregnant teen to notify her parents of her inquiry about an abortion?

A. Yes. For instance, if the young woman who comes to me and explains her fear of parental notification is because her father or her mother or both of them are physically violent toward her, they have beaten her on many occasions in the past, the risk of physical harm to her is real and significant in those instances.

Q. Do those occasions occur, Doctor?

A. They certainly do.

Q. On a regular basis?

A. On a regular basis.

The other problem is the situation where a pregnancy has been conceived by incest. This involves very often a stepfather, in some instances an older brother or in a few instances a true father.

In those, notification of the parents is going to cause a major conflict within that family unit and often [63] physical harm to the young woman.

Q. Do you see those cases frequently, Doctor, or infrequently?

A. I was very surprised about three years ago, I prepared a series of abortion procedures by four different

techniques, a hundred patients in each series, a total of 400 for presentation in a district meeting of the American College of Obstetricians and Gynecologists. That was 400 consecutive procedures.

In that 400 I had 17 girls age 12 and under, and of the 17, 11 of them were pregnant by incest.

So, I would say, in my experience, it is a very common situation.

Q. Doctor, turning now from physical well-being to emotional well-being, would it ever pose a threat to an adolescent's emotional well-being to notify her parents?

A. Well, certainly in addition to physical trauma, in my estimation a form of child abuse is emotional abuse where the girl is berated, degraded by her parents following discovery that she is pregnant.

That poses a very significant emotional hazard to a young woman.

Q. Is that a frequent or infrequent occurrence, Doctor?

A. I find it to be a fairly frequent occurrence.

Q. Drawing on your experience and professional opinion, [64] is there ever a threat posed by parental notification to family stability?

A. Well, certainly in the case of incest the family is torn apart by discovery that a stepfather has been involved in an incestuous relationship with his stepdaughter.

In other situations, the usual reaction that we see of the father is to blame the mother, "You did not rear our daughter correctly; it is your fault that she is pregnant."

In many instances, probably counted in the hundreds in follow-up of the young women and of the situation

at home, I find that the involvement of the family has caused a disruption and a splitting of the marital pair.

* * *

[65] Q. Turning for a second to the other side of the coin, would it ever cause the parents of an adolescent who is pregnant any health-related problem if you notified them?

A. We certainly hear this request often, "My father is in the hospital with serious heart disease; my mother had a mastectomy last week and they found she was inoperable and she is very, very sick. I am afraid if she knows it, it may kill her."

I don't know how often this might happen, but certainly I realize that it poses a significant threat in those few instances to the physical well-being of one or [66] both of the parents.

Q. Why not just notify the well parent as opposed to the ill one in those cases?

A. That is hard to do, because in instances of serious health problems, there is usually a very close communication between marital partners, and it is difficult for one to hide information from the other.

So, informing one would be, in essence, informing the other in those instances.

Q. What effect, if any, would require a notification in all cases in which an adolescent seeks an abortion have on the likelihood of the performance of the abortion?

A. Well, it would certainly make a number of abortions impossible to perform.

Q. Why is that, Doctor?

A. There are instances where you actually cannot find the parents to notify them and get parental consent.

There are instances I have outlined where, in my professional judgment, it is advisable not to notify the parents, because of sequelae to their notification.

Q. Now, would a requirement of parental notification cause any problem to the physician in his practice as opposed to the adolescent in her life?

A. We in the medical profession really find acting as a policeman is a very foreign and distasteful thing and a [67] time-consuming thing.

I would say, as a general reaction of the physicians, when imposed upon them as a policeman, they simply avoid providing that service.

What I am telling you is it would reduce the number of providers or perhaps get rid of them totally.

Q. Returning to the teen, what is she likely to do if she lives in a community in a context where parental notification is required?

A. Well, if she is adamant in her decision not to notify the parents, she would travel, if financially available, any place she can to receive the abortion where parental notification and involvement is not necessary.

This can involve traveling hundreds of miles, costs involving several days of travel and overnight lodging, as well as I outlined before, the added risk of no follow-up care by the physician providing services.

Q. Are there any other responses that the adolescent would have?

A. Well, the others are she will give up and go ahead and carry the pregnancy to term.

Again, if we want to talk strictly in health risk, that is a greater health risk to her.

Alternately, if she is unable to travel, financially unable to travel, she may resort to attempts at [68] self-abortion. She may seek some very low-cost criminal abortionist or illegal abortionists that still exist today.

Q. What is the likely impact of a notification requirement on the date at which a teen will enter the health care network?

A. Well, the teen, as I outlined, the teen usually delays seeking services because she is afraid to involve her parents. She is afraid to tell her parents.

They have, shall we say, taught her from early childhood on that nice young girls don't involve themselves in premarital sex, and to admit she is pregnant is obviously an admission that she has been sexually active.

If we have a mandatory involvement of the parents before she can even seek information or services, there is going to be a considerable delay.

With delay we increase risks both, you know, physically and mentally.

* * *

[70] Q. Now, turn your attention to the other part of that section of the statute.

If parental consent were required, in all cases, [71] say those in which a judicial proceeding were involved for an adolescent under the age of 15 seeking an abortion, what would be the response of the adolescent to that double tiered structure?

A. Well, again, let me answer by reiterating the younger the adolescent the longer she waits before she can involve her parents in knowing she is pregnant and even when she wishes, in a decision-making process.

If parental notification is mandatory or parental permission is mandatory in all instances, the reaction of the

adolescent is going to be to drive or travel to where she can get the abortion or at least information and entry into the service without mandatory involvement of her parents.

The other options are to say, "I am just going to carry the pregnancy to term," or delay until that is necessary because she is past the point of safe abortion.

The third is resort to her own drastic means, self-abortion, criminal abortionists.

Q. Are the medical risks you outlined for us before with these options applicable here?

A. I think they are even more pronounced in the young adolescent, since statistically her risk of a health and emotional hazard associated with an abortion are higher than those of the women in age 20 to 24, for instance.

[72] Q. Would the requirement of parental consent in every case, say when there were judicial consent, create any problems in the practice of medicine for the physician?

A. Again, I will restate that acting as a police—acting as an enforcer is very foreign to the entire medical profession.

We are a crisis-oriented group to provide service at a time that it is needed and necessary.

The reaction is going to be to simply avoid providing these services, rather than involve ourselves in that type of activity.

Q. You may have already answered this, Doctor, but what effect, if any, would the parental/court consent requirement have on the likelihood of the performance of abortions on young teens?

A. It would certainly diminish it or make it essentially unavailable, particularly since we are talking here of a single city and the girl can travel one and a half or two hours down the road and find the same service.

It is really not going to deny her an ultimate abortion procedure. It simply delays her receiving that and increases her risk.

Q. Now, if that young adolescent, instead of going elsewhere or following the other outlined choices, attempts to avail herself of the judicial procedings, what [73] is the likely effect on her?

A. Well, I really have no experience with judicial proceedings in the State of Ohio. I can only speak from Kansas and Missouri where, number one, the adolescent views anything involving the court or legal matters as an actual enemy and she is very reticent to approaching those services in any way.

Rather than that, she will carry the pregnancy or she will delay until it is far too late.

Secondly, in those two states that I have outlined, the approach through the judicial system seems to grind notoriously slowly, and again we are imposing a delay that I find is risky.

* * *

[78] Q. How would you characterize the nature of these materials?

A. I have called them inflammatory and terrifying. I really consider them to be aimed in that direction.

Q. Do the materials in this section, .06(B), confine [79] the physician in his practice of medicine?

A. Well, no place else that I know of in medicine has the law come along and prescribed exactly what we must

tell a patient prior to performing any kind of surgical procedure in medicine today.

Informed consent is a matter that medical professionals implemented in informed consent. It is very meticulous in informed consent because of the malpractice issue.

I certainly feel that in my own experience and in my own visitation of clinics and the type of material handed to patients and presented verbally, informed consent is very properly presented in most abortion facilities, including the mention that the abortion could lead to loss of uterus, could even lead to death.

Q. I think you may have gotten a little off the track.

A. Okay.

Q. If you were required as a physician to comply with the requirements set forth in subsection six of Chapter 1870, what impact would that have on your practice?

A. Well, it would certainly reduce my practice of abortion.

Q. Why, Doctor?

A. Voluntarily I would find it distasteful and difficult to present this, and I would feel it was a dishonest [80] presentation.

Secondly, I am not wise enough to really predict the stage of gestation. I can't tell the girl, describe anatomically what the fetus looks like when the best I can do is perhaps plus or minus three weeks.

The whole thing is very vague. It is presented, in my estimation, as information to discourage the woman from seeking abortion services.

* * *

[81] Q. Doctor, what effect, if any, does the delay have on the delivery of medical care in general?

A. Well, delay in providing abortion services increases risks because pregnancy advances while you are delaying.

The more advanced, the greater the physical health risks.

Q. Is there any difficulty for the physician in delaying procedures?

A. Well, certainly most of us operate on a very busy schedule, and if the mechanics of delaying are going to occupy some of that time, most of us are going to avoid the types of things that require that delay.

By that, I am saying most of us would remove ourselves from the performance of abortion.

Q. Which women would face the most significant health risk from delay?

[82] A. Well, the very young, because their entry into the health service system in seeking an abortion is later than older women.

The very poor and uneducated, because of their inability to articulate their needs and fight their way through the red tape of a system.

All of these are the ones that are going to be most hampered by any delay, mandatory delay procedure.

Q. What effect, if any, will delay have on the cost of performing abortions?

A. Well, if we implement a record keeping and paperwork system, then it requires more people. More man hours mean more wages and that cost is simply passed on to the consumer, namely the girl seeking an abortion. It will raise the cost.

Q. Could as short a time as 24 hours increase a health risk in the abortion context?

A. I referred to that before. I am not willing to say that 24 hours is going to be a very significant rise in health risks, in terms of physical health.

In terms of mental turmoil and torment the girl is going through, 24 hours may mean a great deal.

It may be a period of time that will tip her to doing drastic things, such as self-abortion or other such things, getting in her car and driving someplace else to [83] seek the abortion procedure.

* * *

[*Cross-Examination by Mr. Bickett:*]

[97] Q. Doctor, let me ask you this also: Dealing with individuals under the age of 15, after the abortion is performed, based on your training, the books you have read, the articles and your own experience, in your opinion, do these individuals go back to the family unit which they left after the abortion is performed?

A. The general rule is they return to the living unit they were in upon becoming pregnant, whether this is a family unit or not.

The young, pregnant adolescent often is not in a usual structured family environment.

So, no, I would not say that they return to the family unit. We are talking about 11, 12, 13, 14-year-olds who become pregnant.

These are generally girls, as I described, these are the prime ages for incest pregnancies. These are the prime ages in the very early teens for the young girl in flight leaving her home, living with a girlfriend, living on the street, living with an older male.

[98] Q. Doctor, so it is your testimony then, even in cases such as the case you have just mentioned of

incest, that if the individual 14 years of age or younger should become pregnant by incest, that after having the abortion, without anyone in the living unit knowing about it, they would be returning to that same living unit after the abortion procedure?

A. Generally in incenst cases, that is not correct.

As I testified earlier, incest cases are usually not brought by either of the parents of that home, but by an interested third party.

As I believe I testified earlier, it is this third party that we request inform authorities. These are the girls who are usually removed and placed in custody of a court as a result of the incest charge.

These are always investigated by the juvenile authorities.

So, no, those girls are not sent back to that same home environment.

Q. Does your clinic, in all cases of incest, instigate the investigation or inform the authorities?

A. Our clinic, as I testified earlier, does not in all instances, but we seek the assistance of the interested third party who usually accompanies these very young girls.

[99] This is often somebody from Social Service, incidentally, or from the school system.

* * *

[*Cross-Examination by Mr. Bopp:*]

[106] Q. * * * For minors, what are the normal reasons for obtaining an abortion?

A. The usual reasons for obtaining an abortion?

Q. Yes, sir.

A. What age group would you like me to run—would you like me to run by age groups?

Q. All less than 18 years of age.

A. Well, the usual is that it was an unplanned, unwanted, undesired and untimely pregnancy in the sense that it would constitute an interruption of her education, her social advancement and so forth.

[107] When we drop below the age of 15, however, we have very, very serious maternal health and fetal health problems that are considerations that many of us consider abortion highly recommended.

For instance, may I cite that a fetus or a child born to a woman under the age of 15 has an average IQ 15 points below the national average. Its birth weight is three quarters of a pound less than the national average.

* * *

[108] Q. So what we are usually involved with in an abortion to a minor is an abortion where it is to be performed for economic, social reasons, rather than medical reasons?

A. I would personally disagree with that statement.

As I outlined before, I feel that the medical reality of mortality risks to the under-15-year-old girl and the outcome pregnancy, outcome risks are true medical indications for abortion.

Q. Is it your opinion, therefore, that there is a medical indication for abortion for every pregnant girl under the age of 15?

A. It is my personal opinion; that is correct.

* * *

[115] Q. Don't you think parents are in the best position to provide you with additional information to determine what is in the best interest of the minor?

A. Absolutely. Parents are in a far better position. In every instance I can, I involve the parent.

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TRANSCRIPT EXCERPTS OF KATHLEEN GOTSHALL

VOLUME I

[*Direct Examination by Ms. Roberts:*]

[127] * * *

Q. Ms. Gotshall, the services that Akrion Center provides, you mentioned pregnancy testing. What is the cost of that service?

A. It is a free service.

Q. The abortion procedures themselves, what is the cost of those procedures at Akron Center?

A. As of August 1st, it is $175 for local anesthetic procedure, $210 for a general anesthetic procedure.

There is a reduced rate for women who are on ADC, Aid for Dependent Children.

* * *

A. The various services that are provided, counseling, [128] the testing, pregnancy testing, abortion procedures that you mentioned; are those scheduled at different times?

A. The abortion procedures are scheduled for Wednesday and Saturday only.

* * *

[131] *The Court:* A lot of your patients come through newspaper advertising; is that correct?

The Witness: Some do. The majority of our patients come from social service referrals.

* * *

[140] Q. Would she be able to obtain—do you refer her to any place in Akron for a second trimester procedure?

A. Not any longer, no.

Q. Why is that?

A. Very simply, we do not know of any physicians who will provide second trimester abortions in a hospital any longer in Akron.

* * *

[153] Q. Now, have you had occasion to do any statistical survey of the complications, the complication rate among patients who have received abortions at Akron Center?

A. Yes.

Q. Referring you to Plaintiff's Exhibit 19, on page two of that exhibit, would you read what it says under No. 9, Mrs. Gotshall?

A. "Known complications: A total of nine patients had to have a repeat D and C. This is less than one percent. Specifically, .08 percent or eight tenths of one percent.

"We have had no major complications during the period indicated," which was May of '77 to December of '77.

Q. How many patients did that period include, Ms. Gotshall?

[154] A. 1,250 patients.

Q. Again, is that information correct, to the best of your knowledge?

A. To the best of my knowledge.

* * *

[160] Q. Ms. Gotshall, have you counseled young women of the age of 14 or 15 whose parents were unaware of their decision to seek an abortion?

A. Yes, I have.

Q. Did you inquire into the reason why they had not informed their parents?

A. Yes.

Q. Do you and do the other counselors at the Center encourage women under the age of 18 to inform their parents that they are seeking an abortion?

A. Yes.

Q. And of those that refuse to do this, do you still perform an abortion for them?

A. Yes.

Q. Have you had occasion to have young women of this age explain to you why they feel they cannot or do not want to inform their parents?

A. Yes.

Q. What kinds of explanations do you get?

A. The primary explanation would deal with—and the circumstances will vary, but in a fear of telling the parent that she is pregnant, and, therefore, admitting that she has been sexually active.

[161] Q. In terms of women under the age of 18, is there special counseling done or special attention given to young women in the counseling sessions with respect to determining their decision-making process about having an abortion?

A. The counselor would certainly be aware of the ages of her patients, and special attention, I would say, yes, would be given to the minor to not only determine whether or not she is firm in her decision, but whether or not she understands what is about to happen.

Q. Are there occasions when it is determined that she

either is not firm in that decision or she does not really understand?

A. Yes.

Q. After efforts to resolve those problems, is there still some difficulty with respect to that young woman's making the decision; has she ever been refused an abortion on that basis?

A. Yes.

Q. At your Center?

A. Yes.

Q. Specifically why?

A. If we do not feel that a woman has firmly made up her mind to abort, we will not do the procedure.

* * *

[162] Q. Directing your attention to Section 1870.07, the ordinance requires that 24 hours elapse from the time a woman seeking an abortion has signed the consent form that is required until the abortion can be performed.

What would be the impact of this required waiting period on, first of all, the patients at your Center?

A. If a woman is coming to the Center for an abortion procedure and is coming from out of town, it may very well involve an overnight stay in Akron, which could mean possibly two days, loss of work time for her, or she may incur other expenses, day care expenses, babysitting [163] expenses might be involved.

Also, if she is scheduled for a general anesthesia, someone does have to accompany her. So, those same expenses could be incurred by another party.

Q. Now, general anesthetics are given when, on what days of the week?

A. On Saturday only.

Q. So if a woman came to the Center, had her counseling, signed her informed consent form on a Friday afternoon, is it possible she might—and needed a general anesthetic, that is, a general anesthetic was indicated or she elected to have a general—is it possible she would have to wait another week for the abortion?

A. Yes, very definitely.

Q. And might that, if she were in the 12th week, then preclude her being able to obtain an abortion at the Center?

A. Yes.

Q. What problems would the waiting period of 24 hours provide for the Center in terms of additional staff or additioanl hours?

A. Well, additional staff would be required as well as the physician's time.

Therefore, a greater expense to the clinic, yes.

Q. Now, you mentioned the involvement of the additional [164] time for the physician.

Turning your attention to Section 1870.06, page four of the ordinance, .06 requires that the physician give certain information to the patient in order to inform her fully for her consent under the ordinance.

Now, would you please describe the additional physician time that would be involved with the requirement that the information for the informed consent must be provided for the physician, and that a 24-hour waiting period would be required for that consent.

A. As far as the amount of time that a physician may have to spend, 24 hours ahead of the abortion procedure?

I am sure that it could vary, depending upon the questions that a patient may have concerning the procedure.

I am sure that it could vary from a few minutes to conceivably hours.

Q. You mentiond that procedures are done on two days a week; is that correct?

A. Yes.

Q. And are the physicians that provide medical services at the Center typically at the Center other than those two days?

A. No.

* * *

[167] Q. Now, under the ordinance, if that information must be presented to the patient by the physician, you suggested [168] that it may involve an additional day of the physician's time; is that correct?

A. Correct.

Q. Can you give an estimate about how much more in additional time, an additional day of the physician's time is going to cost the Center?

A. Depending upon the length of time the physician spends at the Center—and I think Dr. Crist testified that a physician may be required to have his payment anywhere from maybe 25 to 50 to 85 dollars an hour, depending upon the length of time, two, three hours at the Center.

It could conceivably cost the Center $250 or more.

Q. On that basis, would the Center be required to increase the cost to the patient for the abortion procedure?

A. Yes.

* * *

[*Cross-Examination by Mr. Destro:*]

[213] Q. Do you consider parental consultation as a counselor, in your experience as a counselor, to be helpful to minors age 15 and under?

A. Sometimes.

Q. On what do you base your sometimes answer? When can it be and when would it not be helpful, in your judgment?

A. If that consultation will be supportive of the patient, then it will be helpful.

Q. When you say "supportive of the patient," does that mean supporting the patient's ultimate decision?

A. Yes.

Q. Then is it fair to say then that you would not consider counseling helpful which might disagree with the minor's decision?

A. Which might be very disruptive, yes, to the minor-parental relationship.

* * *

VOLUME II

[*Recross-Examination by Mr. Bickett:*]

[27] * * *

The Court: What was your field of major in college?

The Witness: Sociology and political science.

The Court: Have you had any medical training of any nature?

The Witness: No formal medical training, no.

[28] *The Court:* Any religious training, other than attending church or going to Sunday school or anything of that sort? Do you have any religious training?

The Witness: Religious training, no.

* * *

TRANSCRIPT EXCERPTS OF DR. CHARLES V. BOWEN

VOLUME II

[*Direct Examination by Mr. Hawley:*]

[30] * * *

A. My name is Charles V. Bowen, M.D.

Q. You are a licensed physician in Ohio?

A. I am.

Q. Do you practice here in Akron?

A. Yes, since 1949.

Q. What is your specialty, Dr. Bowen?

A. Obstetrics and gynecology.

Q. Are you a member of any professional medical societies in Summit County?

A. I am a member of the Summit County Medical Society, the Akron Obstetrical and Gynecological Society.

Q. Are you an officer in any of those societies?

A. I am Secretary of the Summit County Medical Society.

Q. Are you a committee member in any of those societies?

A. I am a committee member of the Maternal and Infant Health Committee.

[31] Q. Are you a past officer of that Maternal and Infant Health Committee?

A. Yes, I was Chairman for about 10 years.

Q. When did your term expire?

A. This year, when I became Secretary of Summit County Medical Society.

Q. Have you had occasion, Dr. Bowen, to inspect any of the abortion clinics here in Akron?

A. Yes, I have had an occasion to inspect all three of them.

Q. When did that occur, sir?

A. About January of this year we went through them twice, on two different occasions.

Q. When you say "we," who is that?

A. The Summit County Medical Society. We had an Audit and Review Committee for this occasion. It consisted of Dr. Keck from the Public Health Department, Dr. Ernest Estep, who at that time was Medical Director of Planned Parenthood, and myself who was representing the Summit County Medical Society and the Maternal and Infant Health Committee.

The Court: Do I understand, sir, you examined the facilities?

The Witness: Yes.

The Court: Is that correct? [32] Were you there during the course of the days that any of these clinics were performing abortions?

The Witness: I witnessed one in every one of them.

The Court: One in every one, you were there?

The Witness: Yes.

* * *

Q. Regarding Plaintiff's Exhibit 50, Dr. Bowen, who authored that document?

A. I beg your pardon?

Q. Who authored it, wrote it?

A. The Council of the Summit Medical Society agreed that several of us should testify at the City Council

meeting, and I was selected as one of those to [33] testify. I wrote this myself.

It was certainly preread by the President and the Executive Secretary of the Summit County Medical Society, but I personally wrote it.

* * *

Q. Does this Plaintiff's Exhibit 50 express the views of the Council or yourself or both?

A. I would say definitely both.

* * *

[34] Q. Regarding the sentence I just read, Dr. Bowen, is that in fact your opinion, that there is no medical need for an ordinance?

A. Yes, it is. I repeat, after we have had the opportunity to inspect all three clinics and they cooperated with us very well.

Q. Again, turning your attention to the statement near the bottom of the second page, the last full paragraph on the page concludes with the words, "Up to this point in time, the abortion clinics are doing an adequate job."

Do you stand by that statement, Dr. Bowen?

[35] A. I do.

Q. Again, on the second page of Plaintiff's Exhibit 50, the previous paragraph to the one I just read concludes with the sentence, "The SCMS was not asked for any professional advice by the proposers of this ordinance;" is that true, to the best of your knowledge?

A. It is definitely true to the best of my knowledge, yes.

* * *

[*Cross-Examination by Mr. Dandrea:*]

[43] Q. Can you state, if you remember, Doctor, how long you stayed at Women Care?

A. I would say at least an hour.

* * *

Q. And in the course of that time that you were at Women Care, did you witness any counseling being performed by the counselors with any prospective women to have abortions?

A. I did not hear what was being said, but I mean, as we went by, they said, "In this room there is a counselor talking to one of the patients."

* * *

[45] Q. After your visit to Women Care, Doctor, did you make any recommendations to the Director with respect to changes that should be undergone at that clinic?

A. Specific ones, you mean?

Q. Yes.

A. Yes, there were a couple in the way the physical layout of the room arrangement was. We felt that a few things could be changed, which they did, in an architectural way.

In the beginning we were a little concerned somewhat about their sterilizing technique, which was certainly corrected.

* * *

[46] Q. You mentioned, Doctor, you visited each of the other two clinics?

A. Yes.

Q. How much time did you spend at the Akron Center for Reproductive Health?

A. I would say about the same amount of time.

I mean, because after I made a tour of the place, we did, Dr. Estep and myself for sure, on that one, the first time around, I am talking about.

Then we sat down and talked to the supervisor, you know, the Director, and asked her certain things about fees and what they included, you know.

So, we spent, I would estimate, certainly 45 minutes to an hour there.

Q. Did you witness any counseling there, Doctor?

A. Only from the same standpoint, where I actually saw a patient in a room with a person talking.

I do not know who the counselor was or her credentials or anything else. I did witness two people in a room talking.

* * *

[47] Q. With respect to that doctor at Akron Center for [48] Reproductive Health, would it be fair to say, Dr. Bowen, that on that occasion that doctor had little or no conversation with that patient before performing the abortion?

A. Yes, I would say he was, you know, until she came in the room and was on the table, prepared, he spoke to her.

I mean, that is all I actually saw. I am assuming that they had a conversation somewhere before that, because they usually are certainly examined by someone before the abortion is performed to determine how far along they are and everything else.

I am certainly assuming that he saw her at some time before the abortion was actually performed.

* * *

[49] Q. With respect to all three clinics, do you have a recollection, Doctor, whether or not on the visits to each of those three clinics you saw a physician counseling a group of women or an individual woman outside the Operating Room or a place set aside for operating?

A. No, I did not see that in any of them.

* * *

[50] Q. Would it be fair to say, in other terms, then, Doctor, that you had some concern on the visit at least to one of these clinics that perhaps they were trying to do too many procedures on a given day?

A. I don't know whether I could say they were doing too many, but I thought the setup in the beginning, that they would have to prove to have enough—I mean, enough equipment and everything else to do the volume.

* * *

[51] Q. * * * Doctor, would you state, then, in your own terms, why you visited the clinic, either the first time or the second time?

A. Very definitely. Because the Summit County Medical Society, if there were going to be abortion clinics in Akron, the one and only thing that we were concerned about was that they were going to be well run medically, and that was the only thing that we really felt our duty was.

So, as long as all three clinics so far have allowed us to come in voluntarily to inspect them to our satisfaction, then we feel very comfortable with the whole situation and we see no reason to change that.

Q. Upon your visiting the clinic January, March of 1978, some of these clinics had been in operation for at least 14 months; isn't that so, Doctor?

[52] A. That is true, but by the time we got our mechanism—after all—we feel this is our responsibility, very definitely, but by the time we got the mechanisms together and decided who should do it and what representation we should have, well, it just took that long to do it.

Even now we have no decided exactly how often we think we should go back.

Since this ordinance has come up, why, we are not quite sure where we stand.

Should we continue to press and take it over ourselves or wait and see what somebody else is going to do?

But, we had several meetings on the way to handle this whole problem about the time that the ordinance was introduced, and it is certainly being followed through to some degree. But, as to how often we feel we should check these clinics now, why, it really has not been decided.

But, if we are left alone, I am sure we will.

Q. May I direct your attention, Dr. Bowen, to Exhibit 50 in front of you, page three, paragraph one, the last sentence:

"We did not realize that the ordinance would be amended as it was or we would have spoken out against it much sooner."

Would it be fair to say that the proposed ordinance [53] here and publicity surrounding it was what prompted your visit and your fellow colleagues to these clinics in January and March of '78?

A. No, I do not think that at all.

When the Supreme Court ruling first came down, we immediately, the same month, through our City Council or through our Medical Council, why, our own Maternal Infant Health Committee and the Public Health Committee drew up what we called some guidelines with the idea—at that time, there were no clinics open, but we drew up guidelines that hopefully that anyone who was going to open a clinic would be willing to follow.

Remember, we had no enforcement on these things. We can only ask for their cooperation.

The things that we were mostly concerned about then was the caliber of doctors who were doing the abortions or who would be doing them, and the facility where they would be done.

In the beginning we even hoped maybe one or two of the hospitals would be able to have a space, you know, for a clinic like this rather than having a separate entity like they are now.

But, of course, nothing ever came of that.

I am just saying, from the word go, we certainly got involved. Whether 14 months is a long time to make the [54] first inspection, well, maybe. I don't know.

But, once we did get into it, then we certainly, I think, followed through pretty well.

Q. May I ask, Doctor, what other clinics or type of clinics do you personally or do other representatives of the Summit County Medical Society visit?

A. No, because most of them, we assume were sort of under the jurisdiction of Dr. Keck, you know, and the Public Health.

We have an excellent—one of the best in the country—review systems for the homes for the—whatever you want to call them—the old people. All the nursing homes are inspected every month by doctors.

I certainly don't go over too often anymore, but in the beginning, when the Health Department set up their prenatal clinics, which I personally helped with, I used to go over and visit and just watch how things were done there. It was run mainly by the residents from the different hospitals.

* * *

[61] ***The Court:*** So, therefore, if a clinic did not have pre-examination by a physician of females prior to the time they are brought in the room for performing the abortion, then the statement that was made of the physicians, of the SCMS are only interested in making sure that all abortion clinics are well run from a medical viewpoint and up to this point in time the abortion clinics are doing an adequate job; then you assume from that [62] that pre-examinations were made prior to the time the abortion is being performed. Is that correct?

The Witness: Absolutely, to the best of my knowledge.

The Court: That would be essential?

The Witness: Sure, yes.

The Court: If they were not, those examinations were not being conducted by a physician, then—

The Witness: Then I would say they ought to be closed up.

* * *

[63] Q. One question, following up on that.

The pre-examination you are referring to is a pelvic examination by the physician; is that correct?

A. Yes.

* * *

Q. Does the pre-examination include counseling, Doctor?

A. It is my understanding, to my understanding, yes.

I mean, if I can believe them, what they tell me their procedure is, yes.

* * *

TRANSCRIPT EXCERPTS OF DR. FELIX P. HEALD

VOLUME II

[*Direct Examination by Mr. Landsman:*]

[67] Q. Are you a licensed physician, sir?

A. Yes, I am.

Q. Where are you licensed?

A. Pennsylvania, Massachusetts, District of Columbia and Maryland.

Q. Are you Board certified in any specialty, sir?

A. Yes, pediatrics.

Q. With any subspecialty of that?

A. Adolescent medicine.

Q. Do you have any articles in publication?

A. Yes.

Q. In what field?

A. Adolescent medicine.

Q. Are you a member of any learned societies, sir?

A. Yes, the Society of Pediatric Research, American Pediatric Society, American Academy of Pediatrics, Society of Adolescent Medicine.

Q. Do you have any honors, sir?

A. Yes.

Q. What are they, sir, if you can recall? Or are they simply in your vitae?

A. Pardon?

Q. Are they recorded in your vitae?

A. They are recorded.

Q. Do you do any consultations at this time, sir?

[68] A. Yes.

Q. Of what sort?

A. For the Federal Government, I serve on two consulting groups for two different parts of HEW.

Q. What are those consultations involved with?

A. Well, the one committee that I have been on is Maternal and Child Health Committee of HEW, which is research review on it.

Q. What is your present position?

A. I am Professor of Pediatrics at the University of Maryland, School of Medicine, and Director of the Division of Adolescent Medicine at the University Hospital.

* * *

[77] Q. When you say "particularly very young," what age do you mean, sir?

A. I am talking about the 15 and under.

As the whole issue of teenage pregnancy is clearly related to maturation and age, and since age is probably the best issue of maturation that we have, the younger the teenager the more adverse is the outcome of the pregnancy likely to be.

* * *

[78] Q. What is the length of gestation at the time of abortion for adolescents, when do they come in for the abortion?

A. Unfortunately, they tend to come in late, later than other women.

Q. Does the delay have any health-related consequences?

A. Yes, it does, clearly does.

The later they seek abortion or prenatal care, the more adverse it is.

Q. Why do adolescents seek abortion at a later time in their pregnancy generally, or seek care later in their pregnancy?

A. Well, there are multiple reasons.

In the first place, they are not as experienced in recognizing pregnancy. They tend to deny pregnancy if they suspect it, because it is such an unpleasant thought.

[79] They are fearful of the reaction of people around them, their peers, their parents. They are afraid to tell anyone.

They are afraid; they do not know the medical system. If they want to seek help alone, they are afraid of the medical system and do not know it well, so almost everything tends to delay and is against early entry into the system, which is in their favor.

Q. As a medical matter, what are the complications of this delay?

A. Well, again, the later one deals with the issue of pregnancy and deciding whether to carry to term or to seek an abortion, the more adverse is the outcome theoretically.

Q. Knowing these factors, what do physicians who deal in the area of adolescent medicine do in providing health care to adolescents?

A. Well, they try to create a system which removes as many impediments to medical care and the decision-making process that the teenager and their family, if they are involved, need to go through in coming, arriving at an appropriate decision.

* * *

[80] Q. Doctor, what is your general attitude about parental involvement in the provision of medical care, including abortion, to adolescents?

A. Our position is very clear. We encourage the teenager to seek parental involvement and encourage them to be involved in the decision making so they can support their daughter in whatever they decide to do.

Q. Have you ever encountered situations in which an adolescent refuses to have her parents involved in such a way?

A. Yes.

[81] Q. Has this occurred in the abortion context specifically?

A. Yes, it does occur with some frequency, particularly in the older teenager, the teenager who tends to be more independent and/or who has been in many ways abandoned by their parents, parent or parents. They will, you know, seek their own.

Q. What motivates this adolescent's resistance to parental involvement, if you know, sir?

A. Well, their reason that they give us is that, "My parents would be so angry they would kill me."

These are words that I have heard a number of times.

So, it is fear of parental disapproval and real anger and nonsupport.

They just do not want their parents to know, and they are adamant about it.

Q. Are these fears and perceptions realistic, sir?

A. Oh, I think so. I think we have had—clearly our experience has been that when youngsters have been fearful but have decided to involve their parents, that

their fears have been realistic, that they have had a hard time with their family.

* * *

[83] Q. Can an adolescent give her informed consent to abortion; is she capable of making that decision without parental input?

A. Yes, but I think it needs to be qualified.

I think it is age related.

12-year-olds, for example, I think it would not be appropriate.

There are some 14-year-old youngsters who are mature enough, who I would respect and feel that they understood the issues and could make the decision, but certainly 15, 16, 17-year-olds, by and large, the older they are the more capable they are of making an understandable and conceptual decision.

* * *

[86] A. * * * Generally, teenagers, if you treat them as adults, they tend to be intimidated easily. They are unsure of themselves, and they do not respond. They do not have the coping skills that adults have, and this is why, in part, there are teenage clinics.

Q. Are their responses different from those of adults in these exchanges between physician and patient?

A. Yes.

Q. In what ways?

A. They tend to be less responsive. They do not have the confidence to engage in the kind of conversation that an adult would with their physician.

Q. Why is that?

A. I think in part they are frightened. They do not have the experience.

Fear of the big medical system and health system is how they measure it.

* * *

[*Cross-Examination by Mr. Bickett:*]

[91] Q. At your clinic, approximately how long does each patient go through abortion counseling prior to the [92] procedure?

A. It varies. Some youngsters it can be done in an hour. Other youngsters, it will take multiple hours.

It depends on the nature of the issues involved, the age of the youngster.

Q. At some time prior to the procedure itself, is it part of your clinic's requirement that someone with medical training or background talk to the individual?

A. No. Medical training, I am not sure what you mean. You mean M.D., nursing?

Q. A degree in the medical field, nursing, M.D.

A. No. Well, the initial counseling is given either by a physician or one of our nurses. That just happens to be the way we are staffed.

Q. Do you think it advisable that they receive counseling from a nurse or a doctor, someone trained in the medical field?

A. I think at one point they should be, yes.

Q. Should this counseling by the physician or nuse take place well in advance of the procedure; should there be a time lapse between the counseling and the procedure itself?

A. Not particularly. Again, it is an individual matter.

Q. Should the counseling, as a typical matter, take [93] place in some place other than the procedure room?

A. I think the setting is irrelevant. I think the cast of people is highly relevant.

Q. Earlier you gave statistics on mortality rates, I believe, for childbirth.

Do you have a comparison between the mortality rate for adolescents for an abortion versus the mortality rate for adults in the abortion, when having an abortion? Is there a comparison there?

A. I would have to check and look.

Q. Well, could you?

A. Which I can.

Q. Do you know whether the mortality rate for minors is higher than that for adults?

A. In abortions?

Q. In abortions.

A. I am uncertain. I don't know.

Q. Do you know whether or not the morbidity rate is higher for minors in performing an abortion than it is for adults?

A. I am uncertain, but I could sure find out pretty fast.

* * *

[*Cross-Examination by Mr. Destro:*]

[100] Q. Are you aware or have you done any psychological studies on your minor patients with regard to any subsequent psychological complications they might have had?

A. I am aware of the literature.

Q. Do minors, in your experience, suffer psychological complications?

The literature suggests that those youngsters who are emotionally healthy prior to abortion remain so afterwards, and those who are emotionally disturbed before abortion are emotionally disturbed afterwards.

There are two different—there are differences following abortion in teenage behavior.

One is that they would not like to have an abortion again. Secondly, they are consistent contraceptive users.

* * *

[107] Q. Do you have any basis or any information relating to the type of guilt that minors feel, where it is derived from?

A. I am not sure what you mean by type.

Q. Would the guilt, for example, that you say that minors feel relate, for example, to parental attitudes that the minors might perceive their parents as having?

A. Well, it is a society guilt.

Generally, teenagers are not expected to be pregnant.

The guilt is less now than it used to be, but it is a pervasive society and has, in the past, been a pervasive society taboo.

That residue still is with us, and there is not a teenager that we see that is not upset and guilty about being pregnant.

I don't see any need to intensify that.

* * *

[109] Q. In your judgment, Doctor, is it advisable for a doctor to delegate the information gathering process from a minor to a surrogate, such as a counselor or a nurse?

A. Some counselors are much better counselors than physicians.

Q. In terms of gathering a medical history, for example, Doctor?

A. Some nonphysicians are much better than physicians in gathering information from teenagers.

* * *

[110] Q. In your judgment, Doctor, are adolescents aged 15 and under generally able to give you an adequate medical history of themselves?

A. Yes, they are pretty good.

* * *

TRANSCRIPT EXCERPTS OF NORMA GOLDBERGER

VOLUME II

[*Direct Examination by Ms. Roberts:*]

[123] * * *

Q. In what capacity are you employed?

A. I am the Clinic Coordinator.

Q. As Clinic Coordinator, would you describe your duties and responsibilities?

A. I hire and fire all employees, coordinate the time, the patient appointment times with physician availability times, pay invoices, order supplies.

I do some public relations.

Q. This would be general administration of the clinic?

A. That is correct.

Q. Ms. Goldberger, would you please describe your educational background?

A. I have a Bachelor's and Master's from the University of Toronto, medical sociology.

I have completed my Doctoral comprehensives at Boston College, all but dissertation.

In addition, I spent one year at Florence Heller School of Social Work, Brandeis University, and one year at the University of Michigan School of Medical Health Medical Care Organization.

Q. Where, prior to the opening of Akron Women's Clinic, where were you employed?

A. The professional jobs that I have had—I was a [124] college teacher at a junior college in Boston and then after that I was the coordinator of problem pregnancy counselor at a free clinic in Columbus, Ohio.

Then I was a counselor at an abortion clinic at Columbus, Ohio.

Then I was a director of an abortion clinic in Columbus, Ohio.

Q. That directorship at the clinic in Columbus was immediately prior to coming to Akron?

A. Coming to Akron, yes.

* * *

[127] Q. Now, does that mean that you do not provide second trimester abortion procedures at your clinic?

A. Yes.

Q. Is there a reason for that? Why don't you provide second trimester procedures?

A. We do not because the original Akron ordinance law that was passed a year ago said that we were only [128] permitted to do abortions in an outpatient setting up to 12 weeks gestation.

A. If it were not for the ordinance which prohibited providing second trimester procedures in the clinic setting, would you provide second trimester procedures to women requesting them?

A. Yes, our physicians would.

* * *

[134] Q. Now, referring to Plaintiff's Exhibit 26, would you explain the purpose of this form, Ms. Goldberger?

A. This form states very clearly the policy of our clinic. That is, that we do encourage minors to inform [135] their parents about the procedure.

If the minor says that she cannot tell her parents, then we want her to write out the reason why she does not

feel she can talk to her parents about this, and she is told in writing that, should there be a medical complication, her parents would be notified.

This is very helpful for our doctors to read before they start discussing with the minor her decision for having the abortion.

Q. So, what you are saying is that these forms—that is, if you have a patient who is under the age of 18, this form is provided?

A. Yes.

Q. And is the form then provided, read by the doctor?

A. Yes, and by the counselor as well. This also will be a guide for the counselor in her approach to talking over the situation with the client.

Q. At what point is this provided to the physician?

A. This form is included in the medical chart and it is provided at the time that the doctor sees the patient.

* * *

[138] Q. Then, if you would describe, please, the procedures that are followed by the physician at that point.

A. Surely. The doctor first reads the medical chart and pays particular attention to whether she signed the consent form.

If she is a minor, he pays attention to what she has said on the minor consent form.

Then he will do—he might review some medical history questions with her before he does the pelvic.

He will do the pelvic examination and he might then review some more medical history if, for example, he finds a scar on her abdomen.

After he does the pelvic exam, he will then ask her if she has any questions and if she wants him to proceed and do the abortion.

If she has questions, he will spend the time and answer the questions.

If she says, "Go ahead and do the abortion," then he proceeds and does the abortion.

Q. Is each patient always asked specifically by the physician, following the physical exam and before the procedure?

[139] ***The Court:*** She can only testify as to the ones she has been there on. You are asking does he do it all the time.

On the occasion when you have been present.

The Witness: When I have been present, the doctor has always asked, "Do you want me to proceed and do the abortion?"

Unless the patient says, "I hope you can do the abortion; I want you to do the abortion"—if the patient voluntarily, as soon as he walks in, says, "Please, do it as soon as possible; do it," then that is the only occasion where he does not then ask her again.

* * *

[140] Q. Now, the waiting period required under the ordinance pursuant to this section would be 24 hours from the time of the informed consent and the informed consent under .06, if you will look at that section, must be provided by the patient's attending physician.

[141] Have you discussed with your physicians the impact or the consequences of the requirement of the attending physician to provide this, these statements, to the patient 24 hours before that same physician performs the abortion?

A. Yes, I have.

* * *

Q. Ms. Goldberger, you mentioned that there are four physicians providing procedures at your clinic. Is that correct?

A. That is correct.

Q. You mentioned that the procedures are provided on three days of the week.

[142] A. That is correct.

The Court: And further, there is just one there at a time; is that correct?

The Witness: That is correct.

By Ms. Roberts:

Q. And is there a reason why there is only one physician there on a given day?

A. Our doctors have full private practices and they can only give us a certain amount of time per week. It is adequate to have one physician at the clinic on a clinic day.

Q. What is the time that is given to the clinic or provided to the clinic for medical services by each doctor per week?

A. Approximately six or seven hours by each physician.

Q. Which would be one day for each physician?

A. Typically.

Q. Under the ordinance, the requirement that the attending physician give the statements required under the informed consent provision to the patient at least 24 hours before he performs the procedure—would that

require that a physician be at the clinic more than one day a week?

* * *

[143] ***The Witness:*** Well, it would require the doctor to be present more than once.

* * *

Q. If your physicians would be required to spend more than one day per week at the clinic in order to conform to the requirements of the ordinance, what would be the impact of that on the clinic?

A. They may choose not to do so, and in which case the [144] clinic would close or alternatively, they may decide only to do it for a fee, in which case we would have to raise our fees.

* * *

[***Cross-Examination by Mr. Dandrea:***]

[156] Q. Currently, what are your procedure days?

A. Wednesday afternoon, Wednesday evening, Friday and Saturday.

Q. Not Tuesday?

A. Tuesday is our day that we use if we have a volume of patients that warrants an extra day opening.

* * *

[162] Q. May I ask whether or not any attempt was made to engage a local physician?

A. Yes.

Q. As an extra doctor to put on for these procedures in January?

A. Yes.

[163] Q. Was that successful?

A. No, it was not.

Q. The local physicians apparently were not interested?

A. I asked the clinic's Medical Director to find a local physician who would be interested. He came back and said, after making inquiries, he could not.

* * *

[*Cross-Examination by Mr. Destro:*]

[183] Q. How many minors, to your recollection, come in with their parents when they come in?

A. Very few of the 17-year-olds and most of the under-17-year-olds.

* * *

[184] Q. Did that minor or have those minors, to your best recollection, told you that they have advised their parents?

A. Some minors have said that, yes.

Q. The others, I take it, then, have put down a reason why they cannot tell their parents; is that correct?

A. That is correct.

Q. Do you discuss that reason with the minor?

A. When it is not too distressful, yes.

Q. What criteria do you use to determine whether or not such discussion would be distressful to the minor?

A. If I feel it would not contribute to her feeling of well-being at the clinic and her feeling of well-being [185] with the decision, then this is not a topic that is brought up.

As an example, if she is telling me that her parents are both dying in the hospital of cancer, then it is not relevant to talk about this.

Q. Has that happened, in your experience?

A. Yes. Usually not both parents, but where the child has only one parent who is remaining and that one parent is terminally ill.

Q. I believe you stated on questioning by Mr. Dandrea that generally patients come to the clinic having made their decision; is that correct?

A. Correct.

Q. Would this also hold true for minors aged 17 and under?

A. Yes.

Q. Would it also hold true for minors under 15?

A. Yes.

* * *

[189] Q. In your experience, Ms. Goldberger, do the minors which you have seen or did the minors which you have seen under age 15 have the capability, in your judgment, of making an informed consent to undergoing an abortion procedure?

A. Yes.

Q. On what basis do you judge this capability; what criteria did you focus in on in determining that?

A. On their ability to state the benefits of not being [190] pregnant in their life and the disadvantages of continuing the pregnancy in their life, in their circumstances.

* * *

[193] Q. Did any of them, to the best of your recollection, change their mind?

A. There have been several occasions where minors came in and, on the day of the abortion, told us that they were being coerced into the abortion by their parents and did not want to have the abortion.

So, we sent them home after sitting down and counseling with them to find that they would then return in two or three days to say that it really was their idea and [194] they really did want to have the abortion after all.

* * *

TRANSCRIPT EXCERPTS OF ALAN G. SEGEDY

VOLUME II

[*Direct Examination by Mr. Hawley:*]

[228] * * *

Q. Prior to drafting Plaintiff's Exhibit 42, Mr. Segedy, had you visited any of the Akron abortion clinics?

* * *

The Witness: No.

By Mr. Hawley:

Q. Prior to drafting Plaintiff's Exhibit 42, Mr. Segedy, had you seen any statistics regarding parental involvement in a minor's decision at Akron clinics regarding their daughter's decision to have an abortion?

* * *

[229] *The Witness:* From the Akron clinics?

By Mr. Hawley:

Q. From anyone who purported to represent the facts at the Akron clinics.

A. No.

Q. Prior to drafting Plaintiff's Exhibit 42, I will ask this question in two parts, one, prior to your drafting 42 and, secondly, prior to the passage of the ordinance in late February, 1978.

Had you seen the informed consent material which any of the Akron clinics provide to their patients?

* * *

[230] *The Witness:* No.

By Mr. Hawley:

Q. Either prior to your drafting of Plaintiff's Exhibit 42, Mr. Segedy, or prior to the passage of the final

version of the ordinance in late Febraury, 1978, had you seen any of these statistics on complication rates at any of the clinics in Akron?

A. No.

* * *

[*Cross-Examination by Mr. Bickett:*]

[248] Q. Mr. Segedy, the work sessions which you referred to attending of the Health and Social Service Committees, other than the four major public hearings, were they open to the public, if you recall?

A. I don't think the issue came up, but I would say no.

* * *

[251] Q. Regarding those work sessions at the Health and Social Service Committee, Mr. Segedy, who else do you recall being present, other than Council members or other public employees of the City of Akron?

A. Marvin Weinberger.

Q. Anyone else?

A. That is all I recall.

* * *

TRANSCRIPT EXCERPTS OF STARLETT C. HURST

VOLUME III

[*Cross-Examination by Mr. Dandrea:*]

[36] Q. He is not a native of this country; is that correct?

A. No.

Q. Has anyone ever complained to you that they could not understand the doctor?

A. Occasionally, they have.

* * *

[39] Q. The question is: At some point, you or someone at your clinic administers Valium to the patient?

A. The nurse administers the Valium after the counseling session.

Q. And before the patient sees the doctor?

A. Correct.

* * *

TRANSCRIPT EXCERPTS OF YVONNE BOLITHO

VOLUME III

[*Direct Examination by Ms. Roberts:*]

[61] * * *

Q. What is your educational background, Miss Bolitho?

A. My background? I was graduated from Mount Union College, 1967, with a Bachelor's degree majoring in psychology and sociology. I have attended Kent State [62] University and Akron University for additional course work. I have taken additional training in counseling and counseling education over the years, so to speak.

I am a certified rehabilitation counselor. This is a national certification that I have.

Q. And these—beyond your undergraduate degree, the additional course work that you have done, would that be on a postgraduate level?

A. Yes.

Q. Miss Bolitho, how long have you been employed at Akron Center as the Director of Counseling?

A. I have been employed there since December of 1976.

Q. And prior to that, what was your employment?

A. I was employed at the Goodwill Rehabilitation Center in Canton, Ohio, as the Director of Vocational Rehabilitation Services for a period of eight years.

Q. And what kind of employment experience did that involve?

A. Okay. As the Director of that program, I was responsible for the hiring and supervision of approximately 12 to 14 other professional people, the running

of a dormitory residential program for people involved, clients involved, in that particular program, and the general oversee of that particular program in general.

Q. Miss Bolitho, the residential program that you [63] described, what age groups did this include?

A. Primarily the majority of the people in residence would be between the ages of, say 16 and early 20's—up to the early 20's.

* * *

[64] Q. Miss Bolitho, as Director of Counseling at Akron Center, you stated that you hire the other counselors?

A. That is correct.

Q. Are there specific standards that you use to determine the qualifications of a counsel for your clinic?

A. Yes. I do have particular standards. My requirement is that a person have at least a four-year college degree and experience in family planning in the family planning field.

Q. How many counselors are under your supervision now?

A. Two other counselors.

Q. Would you describe their educational background?

A. Yes. One of my counselors is a graduate from Kent State University in the Allied Health Sciences Program with considerable background and experience in sex education, having worked with the Army in doing sex education at various base hospitals.

My other counselor is currently in a graduate level program at Kent State in counseling and education. She [65] also has experience in family planning through one of the planned parenthood associations in southern Ohio.

Q. And they both have undergraduate degrees?

A. Yes, they do.

Q. Does either of the counselors have a Master's degree?

A. One of them has a Master's degree, and the other one is working on her Master's degree.

Q. Now, in addition to the requirements of education, what other factors are involved in your consideration and selection of counselors?

A. Okay. Certainly the educational background is important. I am also looking for someone who is knowledgeable about the area of problem pregnancy, who is empathetic to the needs of individual women, and who is sensitive to those needs, so I am looking for people with empathy and sensitivity.

Q. Do you require prior experience in counseling?

A. Yes.

Q. And have the counselors under your direction at Akron Center had prior experience counseling?

A. Yes.

Q. Would you describe that experience?

A. Well, I mean—what I was talking about in terms of both counselors having had experience in doing problem [66] pregnancy counseling and in the area of sex education. One counselor, as I indicated, had worked with the Planned Parenthood Association in southern Ohio, and had experience there for that particular program, and the other counselor had done sex education within the hospital setting through the Army.

So, they have both had experience.

* * *

[67] Q. Now, as a counselor at the Center, do you find that some patients have, before contacting the Center, before coming to you for counseling, been counseled by someone else prior to coming to the Center?

[68] A. Yes, we do. I would say that we find approximately two thirds to three fourths of our patients have been seen by other professionals and have been counseled before they come to us.

Q. And under what circumstances would these people have—would these women have discussed these matters with other counselors?

A. Okay. Primarily, they would have discussed, I think, the issue of pregnancy—of an unwanted pregnancy with the people that would have referred them to our agency, which might have been their private physician. It may have been their school guidance counselor. It may have been one of the counseling staff from another social service agency such as a family planning agency, whatever, that would have referred them to us.

Q. Do most of your patients come by referral from another agency or physician?

A. The majority of our patients come to us by referral, which would include social service agencies and private physicians.

Q. Can you estimate how many, what percentage, if you know?

A. Come to us by referral?

Q. That is right.

A. I would say 65 to 75 percent.

* * *

[69] Q. Now, you mentioned that the majority of patients are referred by either physicians or social service

agencies. Now, would this be true to the same extent with younger patients, that is patients under the age of 15?

A. Yes. In fact, probably more true.

Q. So the patient under the age of 15 would, for the most part, have already had prior counseling before coming to the Center?

A. Most likely, yes.

* * *

[72] Q. Miss Bolitho, have you counseled women at the Center seeking abortions who are under the age of 15?

A. Yes, a few.

Q. And are they usually accompanied by their parents?

A. Under the age of 15, yes, usually.

Q. Have there been occasions when they have not been accompanied?

A. Yes, there have been.

Q. And in those situations, do you inquire if they have told their parents?

A. Yes, we do inquire. We specifically inquire.

Q. If the young woman says, "No, I didn't tell them," [73] do you inquire—do you encourage her to tell her parents?

A. Yes, I do. I do encourage her to tell her parents. I also—if she says her parents don't know, I try to find out why they don't know, why she hasn't talked with, you know, at least one parent, try to find out why they don't know and try to talk with them about ways in which they might approach their parents.

I think that probably in some circumstances part of the issue is not knowing how to approach a parent. So, that is one of the things that I might do.

Q. If you get a young woman under the age of 15, who has not told her parents—

A. Um-hum.

Q. —and after your encouragement to tell them, absolutely refuses or says she can't, do you inquire about the reasons that she feels that she doesn't want to or cannot tell them?

A. Yes, I do inquire about the reasons. Sometimes those circumstances for why she won't can be pretty important to know.

Q. What are some of those reasons?

A. I am thinking in particular of two situations that I happen to know of personally of young women who had been physically abused, and their fear, their concern was that [74] additional physical abuse would occur if the parents were knowledgeable of the abortion.

* * *

Q. Miss Bolitho, in a situation like that where the young woman tells you her parents don't know, that she feels she can't tell them, do you ever notify the parents anyway?

A. No, I do not.

* * *

[*Cross-Examination by Mr. Bickett;*]

[76] Q. To your own knowledge, or within your own knowledge, does the patient ever receive medication of any type at your clinic prior to seeing the doctor?

A. Medication prior to seeing the doctor?

Q. Yes.

A. Occasionally.

[77] Q. And what type of medication would that be?

A. If a patient requests a mild tranquilizer, they might be given a mild tranquilizer by the doctor.

Q. Would this request ever mean that a tranquilizer would be given before counseling?

A. No, that is probably where the request might occur. That is probably when the person would make that request, but they wouldn't get the medication at that time. They wouldn't get it until later.

* * *

[84] Q. When you learn of prior physical abuse to a minor, do you report that fact to the doctor at your clinic?

A. In those particular instances, because we did know of it, that information was given to the doctor, yes.

Q. How does that information get to the doctor, as a matter of policy?

A. Well, as a matter of policy, the counselor would tell the doctor that.

Q. In other words, does it always happen that when a clinic learns of physical abuse to a minor, that information is always communicated to the doctor?

A. Yes, yes.

Q. Is it communicated to anyone else, that fact, either within or outside the clinic?

A. It might be. It might be reported to the clinic Director.

Q. As a matter of policy, is it reported to the clinic Director?

A. No.

Q. As a matter of policy, is it reported to any social agency?

A. Not as a matter of policy.

* * *

[88] Q. Yes. To your knowledge, has a minor ever received only group counseling before she had an abortion?

A. Yes.

* * *

The Court: Only group counseling. Minors. Is that normally the case?

The Witness: No. I would say probably, in a situation of a young minor, that would not normally be the case. She would probably receive both.

* * *

[92] ***The Court:*** What is the policy of selecting when other people are brought in?

The Witness: The policy would be that other members of the group would have to okay that. They would have to agree that is all right for this particular person to bring her mother or her sister or aunt or whatever.

* * *

TRANSCRIPT EXCERPTS OF DR. ADELE HOFMANN

VOLUME III

[*Direct Examination by Mr. Landsman:*]

[103] * * *

Q. Are you licensed to practice medicine in any states?

A. I am licensed to practice medicine in both New York and Connecticut.

Q. Are you Board certified in any specialty?

A. I am Board certified in pediatrics.

Q. Is there any subspecialty?

A. I have a specific commitment to adolescent medicine and I am full-time involved in that field.

Q. Have you written any articles or publications in that field?

A. I have written a number of books and a number of articles in the area of adolescent health care, adolescent sexuality, in counseling adolescents, and a variety of aspects of that sort, yes.

Q. Doctor, are you a member of any learned societies?

A. I am a member of a number of societies. I think the ones that are particularly relevant here are the Society [104] for Adolescent Medicine and the American Academy of Pediatrics.

* * *

Q. What is your present employment?

A. I am presently—my functional title is Director of the Adolescent Medical Unit, New York University Medical Center, Bellevue Hospital.

My academic title is Associate Professor of Pediatrics, New York Pediatric Medical School.

* * *

[107] Q. Do you feel that termination of teenage pregnancies by abortion is a valuable medical option?

A. It is an essential medical option in my opinion. We see so many young people whose lives are virtually destroyed by having to go to term, if this is not what they would like to do, both medically and emotionally and socially, and it would be devastating to us now to have [108] to return to the time when this was not an available option.

Q. At what stage in their pregnancy do adolescents generally, not in your clinic, but generally avail themselves of medical care when they are pregnant?

A. I think it is a universal experience that the teenagers come to traditional health care systems extremely late in their pregnancies, generally well on into the second trimester.

Usually, at that time when this is a matter which neither they nor anyone else can deny because pregnancy becomes obvious.

Q. Have they, in those cases you have described, seen other physicians or gotten other care before they come in?

A. No.

* * *

[109] Q. Why are adolescents so slow to seek medical assistance in their pregnancies?

A. We have a society which still views a pregnant, unmarried youngster as a so damaging social issue. There is a tremendous amount of social pressure upon her to publicly declare this or even to herself to recognize it.

She often has a great deal of conflict in her own mind over it. It is an enormous conflict in the family in which the parents may have been raising her on a standard of premarital chastity and which she isn't able to live by that and becomes pregnant.

It is a horrendous conflict of how to tell your parents, so all of these pressures, the social, the inner, [110] the parental fears and concerns really provide a provocative barrier to her to admit to this need and do something about it.

Q. Is pregnancy the only area in which teens are slow to seek medical assistance?

A. I would say this is true of any number of a variety of sensitive health issues or sensitive situations. The argument is equally applicable to young people who have problems with drug abuse, to young people who have mental health problems, particularly when the major conflict is in relation to their families.

* * *

[112] Q. What is your general attitude toward parental involvement in the provision of medical services to adolescents?

A. I am committed to the fact that parents are the best supporters and best allies of their adolescent children and should very much be involved if it is at all possible.

[113] Q. Are there ever occasions when that parental involvement is inappropriate?

A. There are times when the situation at home is such for one of a variety of reasons where it can be harmful.

* * *

[114] Q. Would it ever pose a threat to the physical well-being of an adolescent to notify her parents over her objection?

A. There are a number of ways in which that is possible and indeed has happened. The first is that the advisement that parents must be notified may well precipitate elopement.

One I have seen happen is that the young person runs away.

Q. Elopement from what?

A. Running away from home and from medical care, both. [115] I have seen that happen.

The second area where this may occur is the fact that I have also seen parents beat the heck out of their kids on being told that they were pregnant. We have had several instances in which there has been severe corporal physical punishment inflicted upon the adolescent.

A third I know is the recognized high association in certain selected youngsters of pregnancy with suicide attempts. We don't have the data on suicide completion and usually we are able to stop it from completion, but there is a definite correlation and the requirement and any additional barriers placed into giving her support moving in to meet her needs and the argument that may obtain to parent notification between her may often be the crisis precipitating suicide attempt.

Q. Do you ever find it to be a threat to an adolescent's emotional well-being to notify her parents over her objection?

A. I think that in many ways that it creates a tremendous amount of anxiety in her mind, a feeling of people's—not lack of trust.

* * *

[116] Q. Would notification ever pose a threat to continuation of the family relationship, the family structure?

A. In some instances, and particularly those where there are major variations in the moral value system.

* * *

Q. If parents of all 15 to 17 years old, of adolescents, knew of their daughter's decision to seek abortion, what role will the parents thereafter play in the abortion decision process?

A. This was notification?

Q. Yes, notification, Doctor.

A. There is really so little difference between notification and consent as the minor is concerned. It is a technical issue, both of which require parents' knowledge and that is what the young person is concerned about.

[117] Once a parent knows about the issue, whether through notification or consent, the parent then can exert a force in terms of how that adolescent is going to respond to that pregnancy. It is extremely difficult and, I think, very hard for a 15-year-older who wishes to go into one course to go against her family's wishes once they have been notified.

How can a person 15 years old, whose parents want her to go to term, say, "No, I don't want to"? It is very difficult for young people to bring these adversary practices into their families and it doesn't really belong there.

Q. Faced with the prospect of parental notification, what is the pregnant adolescent likely to do concerning the abortion decision?

A. I think it is very simple. It is going to be just what happened before when we weren't able to give her confidential entry into the care, and that is delay it.

Q. What, if any, health risks are there in that response?

A. The health risks are those I have enumerated before of the increased risk to her really going so late that she would not have the option of abortion and will be forced into going to term, and that is inherent health risks that we have discussed of toxemia, anemia, [118] prematurity in the baby and so on.

Q. Would a requirement of parental notification in every case in which an adolescent elects to have an abortion create any problems for the physician in her practice of her profession?

A. I guess from my perspective, I feel it is somebody telling me how to do my business. It really ties my hands in such a way that I can't do things in a flexible manner which is suited to the individual instance.

I would say that I certainly make every effort in any instance to explore and discuss with the teenager who is pregnant the feasibility and even desirability of involving her parents if she can.

To have this as a required mandate puts me in the position of compromising my development of a trust relationship by bringing kinds of external requirements into the intimacy and privacy of the patient-physician relationship and the way in which I may be able to help her for effective negotiations rather than a kind of an impersonal notification to the parent.

* * *

[119] Q. Is an adolescent capable of making an informed decision concerning whether to have an abortion without parent input?

A. Some adolescents are able very easily to give a decision. I think most adolescents can, with some professional guidance, come to a rational and reasonable decision.

Q. At what age can adolescents manage this decision?

A. Well, there is a developmental concept that has been introduced by a widely recognized theoretician of Jean Piaget in France.

His experience and research demonstrate that young people come to the capacity of abstract thinking, that is [120] an ability to take an experience here and now and look down the road at the future and perceive how this will affect them and to begin to appreciate those kinds of concerns and, to my estimate, that is what is essential; we have found essential for the capacity to give informed consent.

People begin to come to this at 12, approximately, as a wide variation, and generally the capacity for—developmental capacity for abstract and rational thought is fully achieved by 15, so that it is developing very nicely in 13, 14 and 15 and certainly most 15 to 16-year-olds really have the capacity to give an informed consent on the developmental basis.

* * *

All this means the greater the risk of prematurity for the young teenagers. I very frankly tend to feel fairly pro abortion for the very young teenager. It is an unknown quantity versus a young person whose life has not yet even begun to be fulfilled, and I really have to say that maybe we should be encouraging these young people a little more to think of abortion in a rational way.

* * *

[122] Q. * * * Doctor, with respect to parent consent, do parents ever withhold approval for medical procedures which are in the best interest of the children?

A. This occurs with some frequency. Classic is the one, I am sure, that you and everyone else is familiar

with, the instance of Jehovah's Witnesses who refuse to allow blood transfusions that are necessary for saving the life of their child.

Q. Now, does this kind of situation ever arise in the abortion context?

A. It does indeed. We have many instances, as do other people involved, where the young person wants an abortion and my experience extends back into the 1960's, [123] having entered the field in 1963, when abortion was not a consideration at all, and then somewhat later where the parents consent issue was much more rigidly applied than it is today, and there were many young people who were not allowed to have this as an option because their parents would not consent.

Q. Faced with the prospect of parent consent in all cases, say those in which judicial consent were substituted, what is the young adolescent 14 years or younger likely to do concerning the abortion decision?

A. I think she will just delay entry into care until again her pregnancy is very well advanced. The particular young adolescent is typically prone to denial and avoidance of difficulty and anxiety-producing situations, so she simply will not enter into the health care system until fairly late in the pregnancy.

Q. Are the risks you detailed previously with relation to delay applicable here?

A. Even more so for the young adolescent.

Q. Would a requirement of parent consent in all cases, save those that have been excepted, cause any problems for you as a physician in rendering health care to young adolescents?

A. They pose an additional barrier to the exercise of a rational, reasonable approach towards the young person

[124] and their family. They are handcuffs, in essence.

* * *

Q. Would a consent requirement of the sort I have described pose any health threat, either emotional or physical, to a young adolescent 14 or younger?

A. This major barrier is, of course, if a young person [125] knows that they have to have their parents' consent, they simply will not come for care in the first place and, again, this will cause late entry into care and if the parents refuse to permit abortion, it deprives the young person of an option that might really be in their best benefit.

Q. Doctor, if you would examine Section 1870.05(B)(1) with the question in mind: What effect will that have on the health ca and health needs of the adolescent, young adolescent?

* * *

The Witness: Well, this is the specific format in which I, as a physician, would have to operate, and my major question here—and I have addressed the issue of what a consent requirement would obtain—but what would concern me here is how to implement it.

I have had experience in requiring written consent of parents and we have a [126] number of options.

One, we could give the young person a written consent form to take home with her to have it signed. She has three choices. She can throw it away if she walks out and not come back. She can go to her parents and have the parents sign it, which I have already spoken I think it is difficult for a young person to do, or, thirdly, she can forge the signature. We find this happens, and I really dislike very much being placed in a position of encouraging duplicity when I am trying to create honesty and openness.

Another option would be, say, "Go bring your mother in," or have somebody go to the home with the declaration saying, "Sign it." The technique of doing this obviously places an enormous burden in terms of how do you do it.

Parental notification on the signed form the kid takes that is notarized also poses very difficult problems not only for the parent, but for the youngster who can't ask her parents, and for many parents for whom finding a notary becomes a real problem. [127] Inner city parents who have to pay $2 sometimes just isn't done.

So, it becomes technically, and I have considerable direct experience with that, very difficult to implement in the practical way.

* * *

[128] Q. Turn your attention, if you would, Doctor, to the third aspect of 1870.05, that is judicial consent.

Faced with the prospect of judicial consent, providing of course you can obtain parent consent, what is a 14-year-old or younger adolescent likely to do about the abortion decision?

A. Well, at first glance, it really poses an impossible burden. Most young people, in terms of perceiving the judicial system is not that of being their ally. The contact of most young people with the judicial system is in terms of having infracted various rules and regulations.

Secondly, how do they gain access to the judicial process? Perhaps one might say this would be in and of the health care provider, but then this poses enormous [129] problems for the health care provider to have access to the court system.

* * *

Q. Are the medical risks you detailed before applicable in the context where you got this judicial consent procedure in place?

A. I think it perhaps would be even more difficult for a youngster to how they would negotiate a judicial process as a barrier. It adds to what I think this piece of legislation is, an enormous set of cumulative barriers to young people gaining access and going through with needed health care.

Q. Would the judicial procedure I described create any problems for the physician in her practice?

A. It again, from my perspective, does intervene with the therapeutic role that I can play with the patient and [130] their parent by introducing another cumbersome set of regulations that I have to observe in a rigid way and deprives me of the flexibility that I really very much need in this instance.

Q. What effect would such a proceeding have on the relationship between the parent and the young adolescent if the proceeding were to go forward?

A. You know, we have a tough enough time with parents and adolescents in helping them to negotiate communications, and if you introduce an adversarial process where the young person is challenging the parents' right to determine their fate, I think this is really a rather unfortunate state of affairs, to put it mildly.

Q. Will 1870.05(B)(2) of Plaintiff's Exhibit 44 before you have the effects you have described concerning judicial consent?

A. In my opinion, it will.

* * *

[131] Q. Do those varying backgrounds always have to include medical expertise?

A. Well, to be honest with you, I think that probably the physician, in his preoccupation with organic needs, is probably the least well equipped of professional and paraprofessional persons to deal with counseling effectively.

Q. Should the counseling be selected on the basis of formal classroom kinds of education?

A. Well, as we really haven't really developed any standards and we have some, but relatively few formal [132] programs, and as I think, experience has demonstrated that there are a lot of people who can develop counseling skills in in-service training programs, my answer would be no.

I think there is one prerequisite, and the prerequisite can extend for a person of whether there is a peer counselor or whether there is an adult counselor, whether there is an adult who is an indigenous adult to the community, the one requirement is that, in my perspective, is that they have an ability to relate to young people and feel comfortable with them.

* * *

[*Cross-Examination by Mr. Bickett:*]

[140] Q. Where do you refer the patients for the actual [141] abortion procedure? What type of facility, not necessarily the name?

A. We generally refer them to the established clinics in the community. We find that the hospital-based facilities are very generally poor, very insensitive, and particularly, I regret my confreres in my own institution are relatively insensitive to adolescent needs and that the very best of counseling and support systems are available in the free-standing clinics, the free-standing abortion clinics, okay?

* * *

TRANSCRIPT EXCERPTS OF MARCIA M. PARKER

VOLUME III

[*Direct Examination by Ms. Roberts:*]

[183] * * *

Q. Miss Parker, are you employed?

A. Yes, I am.

Q. Where are you employed?

A. At Planned Parenthood of Stark County.

* * *

[187] Q. Miss Parker, will you describe your duties and responsibilities at Planned Parenthood as a counselor and educator?

A. I do the counseling in family planning.

* * *

[189] Q. Now, again, specifically with respect to young women under the age of 15, is a parent usually with a young woman of this age?

A. A parent or a relative usually accompanies the person.

Q. Then, in those cases, is that parent or relative also part of the counseling process with respect to the decision to terminate the pregnancy?

A. Yes, they are.

Q. Now, if the decision is made to terminate the pregnancy, following the counseling, then do you make the referral to an agency for that termination?

A. I do make the referral to the person and that they must call the agency of their own accord.

[190] Q. Do you typically refer your clients to facilities in Akron for the termination of their pregnancy?

A. Yes, I do.

Q. What specific facilities in Akron do you refer your clients to for abortions?

A. The Akron Center for Reproductive Health, because they are a nonprofit clinic, and Akron Women's Clinic.

Q. And Akron Women's Clinic is profit or nonprofit?

A. As far as I know, it is a profit organization.

Q. But you nevertheless refer them to that agency?

A. Yes, we do.

Q. Miss Parker, who selects the facilities for those referrals?

A. Okay. That is done by an evaluation process of Planned Parenthood.

* * *

[194] Q. Miss Parker, were you a part of the evaluation of those facilities?

A. Yes.

Q. And so you participated in those evaluations?

A. Yes.

Q. Did the evaluations include a visit to the facilities themselves?

A. Yes, they did on procedure days.

Q. And what did that visit—strike that.

What did that evaluation involve, that is, what was reviewed during that evaluation?

A. Specifically, the counseling sessions, the qualifications of the staff, whether or not the guidelines were being met as far as the content of the counseling sessions meaning the description of the procedure, the offering

of birth control information, and as far as the medical staff is concerned, the medical equipment that is used, emergency equipment, et cetera, and the qualifications of the doctors and the nursing staff.

* * *

TRANSCRIPT EXCERPTS OF REGINALD K. BROOKS

VOLUME III

[*Direct Examination by Ms. Leitzer:*]

[213] * * *

Q. And please state your current employment.

A. I am an Akron City schoolteacher, curriculum aid specialist. I am an instructor at the University of Akron in the evening college, and I am also an Akron City [214] Councilman.

Q. How long have you lived in Akron?

A. I am a native Akronite.

Q. How long have you served on the City Council?

A. I am in my third year, second term.

Q. Now, could you describe the procedure for introducing legislation into the City Council and its passage through the Council through enactment?

* * *

The Witness: Yes. Normally, a person will sponsor a particular ordinance. He will go into the City Law Department, sit down with the Law Clerk, discuss his idea, what the intent of the law is supposed to do, what the problem is, and at that time, the Clerk will draft the legislation into formal legal terminology.

At that point, it will be sent to City Council, read into the minutes of the meeting, and referred to committee for hearings whereby, at that point, the proposed legislation will [215] undergo the scrutiny of that particular committee charged with the responsibility in that particular are.

They will make a recommendation to the City Council as a whole on the floor when it is introduced, and we will vote on it at that point.

By Ms. Leitzer:

Q. Does the committee ever redraft an ordinance?

A. Sometimes it is sent back and revisions are made.

Q. By who?

A. Usually they are made by the members of the committee. Sometimes deletions are made. Sometimes additions are made, and then it is sent back.

Q. Now, does that redrafting process usually involve members of the committee alone?

A. Sometimes it does. Most of the time it does. Sometimes on a very controversial issue, it involves all of the City Council.

Q. Does it ever include outside interest groups?

A. Yes, we do take testimony from various segments of the community that would have an interest in that particular legislation.

Q. But would those outside interest groups and individuals involved in those groups ever sit down with the [216] subcommittee at a working session and assist in the actual physical redrafting?

A. I have never seen that done before.

Mr. Bickett: Your Honor, I am going to object.

The Court: Objection sustained. I don't understand. You mean is that ever the practice or is there any rule saying they can't do such a thing?

The Witness: I have never seen it done before.

The Court: All right. In other words, that is the normal practice that it is not done, but there is no rule of Council saying you can't do it?

The Witness: There is no rule that I know of, but I have never seen it done.

The Court: Okay, fine.

By Ms. Leitzer:

Q. Now, are bills ever introduced into Council that have not been written by the City Law Department?

A. In my experience in three years, I have only seen two and one was rejected at face value. The other one was this particular ordinance.

Q. Why was—could you explain the circumstances [217] around the other one?

* * *

The Witness: Normally, we don't like to bypass our own Legal Department to have the language correct with our own City Code. We like to have it drafted in the proper format.

By Ms. Letizer:

Q. Could you explain what other ordinance, other than the abortion one—I take it that is what you were referring to—that was rejected at face value? What was it? Who wrote it and when was that?

A. To my recollection, it was an ordinance dealing with establishing a home for pregnant women.

Q. When was that introduced?

A. Just recently. Maybe two months ago.

Q. And why was it rejected?

A. Because it had not come through the proper channels and we felt that we didn't want to depart from past procedures and we sent it back with the recommendation that it go through the proper channels.

[218] *Mr. Bickett:* Your Honor, I would object to the use of the term "we."

The Court: Objection sustained as to the opinion of the other 12 members.

By Ms. Leitzer:

Q. All right. When I ask you these questions, I am referring to your perception, your knowledge.

A. I understand. Okay.

Q. Now, did you and other City Council members receive any abortion-related literature prior to the introduction of the abortion ordinance?

A. Yes. We were inundated by this literature long before we even had mention or heard mention of a pending ordinance.

Q. About how long before?

A. Two to three months ahead of time.

Q. And was there any pending abortion legislation at that time?

A. No, there wasn't.

Q. Is it usual for Council members to be inundated with literature regarding an issue when there is no pending issue?

* * *

[220] ***The Witness:*** Generally. I characterize that by saying that that is what we call lobbying, and normally, that is not done until an actual piece of legislation is introduced. Then, at that time, the lobbying efforts, those for and those against, usually begins, but I have never seen it ahead of time.

* * *

Q. How would you characterize the mail that you [221] received?

A. The mail that I received was pushing or promoting

the idea that abortion was immoral and that it was heavily shaded with Biblical quotations.

Q. Did this flow of literature regarding abortion literature of this nature continue after introduction of the ordinance?

A. It became more intense. . . .

* * *

[223] Q. Do you recall if there was any evidence at those hearings regarding the informed consent practices at the clinics?

A. To my knowledge—are you speaking of here in Akron?

Q. Right, the clinics in Akron.

A. No.

* * *

Q. Did you oppose the ordinance?

* * *

[224] ***The Witness:*** Yes, I did oppose it.

By Ms. Leitzer:

Q. Why did you oppose it?

* * *

The Witness: First of all, I have certain misgivings about abortions myself, but I opposed it largely based on the testimony that was given during the public hearings by the Law Department and the Health Director and the Director of Summit County Public Health Society.

* * *

[225] Q. In opposing the ordinance, did you take into account the recommendations of the City law department?

A. I suppose that was the biggest thing that swayed me. I had certain ambivalent feelings about abortion, as

I said, but being a teacher and teaching constitutional functions and government, I don't believe I have a right to impose my view of morality on other people. It is a rather personal—

Q. What were Mr. Spicer's objections to the ordinance?

* * *

[226] ***The Witness:*** In two occasions during the committee hearings, Mr. Spicer indicated that he would like to be withdrawn from the case and that he felt that it was his opinion that the legislation, as drafted, was unconstitutional and indefensible, and he recommended that we not act on it.

* * *

[227] Q. Now, is there any other time when a City attorney has made a similar recommendation regarding a proposed ordinance that the Council disregarded that advice and went ahead and enacted the ordinance?

* * *

[228] Q. In your experience.

A. I had never seen it.

The Court: How long has Mr. Spicer been over there? He left here what, eight months ago?

By Ms. Leitzer:

Q. Either Mr. Spicer—I am sorry—or another City attorney who was asked advice.

A. Basically, we rely on their opinions and we go along with them, unless there is some overriding reason, but I, in my three years, have never seen it done before. It may have been done, but I have never seen it.

* * *

[229] Q. Getting back to the ordinance, what is the procedure that is followed before a vote or final passage

of a bill? In other words, when you come into a committee meeting and you have on the agenda a vote, what is the normal procedure for passage?

A. The committee reads the recommendation, they hold a vote, they take a tally of the votes, and then it is usually discussed at a caucus meeting, which is prior to the formal City Council session, and at that time, it is debated back and forth how the votes are going to come out, and then we actually vote on it following the caucus session in the formal Council session.

Q. Do you have, at that time, in the caucus session, a copy of the proposed ordinance?

A. Normally we do, yes.

Q. Did you receive a copy of the final version? Let me hand you Plaintiff's Exhibit 44. Do you recognize that? Can you identify that?

A. Yes. Can I identify it?

Q. Yes. Could you identify it for me.

[230] A. Yes. I did not see the final drafted version of the ordinance until after the vote was taken. I never did have the final copy before me.

Q. Is that a usual procedure that you were asked to vote on something which you had never seen the final draft of?

A. It is very unusual. It has happened before, but it is very unusual, especially on something like this.

The Court: It wasn't available the night of the vote, sir, or the day of the vote?

The Witness: Well, there were several people in Council that had copies, but not everyone had copies of the ordinance.

The Court: Did you object at the time that you hadn't seen a copy of it?

The Witness: Well, I read off of the person that was sitting next to me, and I read off of their copy.

The Court: So you did see a copy of it prior to passage?

The Witness: I saw the face cover of it. I never did—you know, there were some problems during that and some people [231] did object to not having the legislation, but sometimes, when legislation comes in late, like a department head needs something passed right away, we have in the past voted on things rarely that we haven't seen, but we don't like to make it a practice.

The Court: That is on lesser important things?

The Witness: Yes.

The Court: On routine things. I understand.

* * *

TRANSCRIPT EXCERPTS OF HENRY DAVID, PH.D.

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[57] * * *

Q. Are you a diplomat in any field?

A. Yes, I am, in clinical psychology.

Q. Are you a certified psychologist?

A. Yes, I am certified and licensed in the District of Columbia and the State of Maryland.

Q. Doctor, have you written any scholarly publications?

A. Yes, I have written a number of books and over 150 articles.

Q. What subjects were those on?

A. They range in the area of psychology as well as [58] population.

Q. And have you, in the last five years, sir, concentrated in any area?

A. Yes, the last five years particularly in the population area. In fact, my latest book was only published last week, "Abortion in Psycho-social Perspective Trends and Transnational Research."

* * *

Q. Have you done any consultation groups, sir?

A. Yes, I am currently a consultant in the World Health Organization, both in the headquarters in Geneva and in the European office in Copenhagen.

Q. Have you done any consulting in the United States, [59] sir?

A. Yes. I was one of the consultants to the National Academy of Sciences Institute of Medicine on the study of abortion and the public health.

Q. What is your present employment, sir?

A. I am currently Director of the Transnational Family Research Institute in Bethesda, Maryland, and I also serve as Associate Clinical Professor of Psychology in the Department of Psychiatry in the University of Maryland Medical School, Baltimore.

Q. What is the Transnational Institute, sir?

A. The Transnational Institute is a private, nonprofit, tax-exempt research organization in behavioral sciences and works primarily in the population area.

Q. What experience do you have, sir, in examining questions of psychiatric sequelae or aftermath to abortion, to pregnancy, and to other questions in the area of sexuality?

A. We have conducted studies in this area since about 1970, have published extensively, reviewed other publications, et cetera.

* * *

[60] Q. Doctor, what does the term "psychiatric sequelae" mean?

A. It is a quite diverse term used differently by different people, but I would like to define it here in its operational sense of being admitted to a psychiatric hospital either following term delivery or following abortion.

* * *

[62] Q. Have you reviewed the literature in this area?

A. Yes, we have.

Q. What, in your expert opinion, is the likely psy-

chiatric effect of abortion upon women with existing psychological problems?

A. The general consensus is that such women have often experienced some relief from their particular psychiatric conditions, but I do want to add that there are occasions when a woman continues to have psychiatric problems, but to the best of our knowledge, at this time, the relief far exceeds the number of difficulties.

Q. Upon what is that analysis based, sir?

A. That is based primarily on studies done of psychiatric patients, both in the United States and abroad.

* * *

[63] Q. What is the likely psychological effect of abortion upon women with no pre-existing psychiatric problems?

A. In the majority, vast majority of cases, it is a feeling of relief.

Q. Is the same conclusion true with respect to minors under the age of 18, sir?

A. To the best of our knowledge, it is.

Q. Can you quantify the likely psychiatric effects of abortion on healthy women, sir?

A. Yes. There has only been one—well, let me put it this way. I think one needs to compare post partum cases and post abortion cases. It is the only real comparison control groups that can be conducted.

To the best of our knowledge, there has only been one major study in the United States of post partum psychosis, and the findings there were between 15 and 25 per 10,000 deliveries.

Q. That is post partum?

A. Post partum, yes. In the international literature, it is generally found somewhere between 15 and 20, and that [64] is a figure I would like to propose.

On the other hand, post abortion admissions to psychiatric hospitals, and that is what I am talking about, range between three and four per 10,000 aborters, and if those figures hold up, as we believe they will in Denmark, the incident or the risk of a post partum admission to a psychiatric hospital is about five times as high—four to five times as high as admissions to a psychiatric hospital after abortion.

Q. If you would again, please look at 1870.06(B)(5) with the following question in mind: What is the scientific accuracy of the statement contained therein that abortion can result in severe emotional disturbance?

A. I would say that the scientific accuracy is very limited because it makes no comparisons whatsoever between relief and difficulties, and anyone who says may or can, I do not consider a scientifically valid statement.

Q. Now, Doctor, in answer to one of your prior questions, you indicated that post partum difficulties, after going to term were more significant than those based in abortion. Could you give us those figures again, sir?

A. Yes. I made—I stated the opinion that the risk, the mental health risk, as defined in terms of admission to psychiatric hospitals, is far greater after giving birth than after having had a first trimester abortion.

[65] Q. Now, sir, is that true for minors underneath the age of 18?

A. To the best of our knowledge, it is.

Q. Doctor, on what study is that based?

A. Based primarily on international conferences and discussions with colleagues. I have not been able to separate these out by specific age, but our experience leads us to believe that this is correct.

Q. Now, for the overall conclusion that you have expressed, is there a United States study?

A. There is no United States study except one small—one conducted at Johns Hopkins University reported in 1973 where groups of women at Johns Hopkins University were compared in terms of first trimester abortion, second trimester abortion, and carrying a pregnancy to term.

These women were examined at the time of the event of the procedure with the birth or abortion and follow-up examinations were conducted about one year afterwards.

A whole range of psychological tests were used as well as psychiatric interviews, and the only statistically significant finding to emerge from this study was that women giving birth had a higher score meaning—showing greater disorder on the psychological test and the conclusion drawn from this study was that psychological risks were higher in women carrying to term than women [66] having abortion.

I would like to add to this that these were not definitions in terms of admissions to psychiatric hospitals, but were definitions in terms of psychological test scores.

Q. Now, were these objective type tests?

A. Yes.

Q. Were they tested?

A. The key test used was the Minnesota multi-phasic

inventory, which is a very well standardized, regarded, and widely accepted psychological test.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[85] Q. You have indicated, I believe, that there is some relief experience by a woman post abortion in your findings; is that correct?

A. Yes.

Q. Would that also be true for a minor?

A. For most minors, yes.

Q. Have your studies indicated whether that relief is a more or less short-term relief, or whether that is a relief of longer duration?

A. Our findings suggest that the relief becomes stronger the further the woman is removed in time from having had the abortion.

In other words, the longer-term effect is much more frequently one of relief.

[88] Q. So your studies now, or some of them did include that factor of parental involvement. Is that your answer?

A. By parental involvement, what do you exactly mean?

Q. What I am referring to is whether or not the parents participated with their minor daughter in the decision as to whether or not to abort?

A. There are examples of cases where a minor did not consult their parents, and there are examples of cases where a minor did.

I find it extremely difficult to make a generalized answer when very often there are very special circumstances in each such case.

Q. Perhaps you can—

A. May I just finish, and I would only say that in the studies that have been done, in nearly every case, the net result was one of relief, regardless of parental [89] involvement.

Q. Regardless of parental involvement?

A. Yes.

Q. If your studies have considered this element, can you tell us what difference parental involvement made, if any, in a minor's resulting relief or psychological problems?

A. Well, I think it goes without saying that any minor who experiences support from parents or any other important person in her life is going to have an easier time.

* * *

[90] ***The Witness:*** The general finding on counseling, and that is the only evidence we have, is that counseling by and large does assist the woman, whether she is a minor or not, but I would want to go back to my previous point, and that is that counseling with minors is important. There is no question of that, but the basic question is: Does the minor—has the minor made a decision?

It is not up to the counselor to make the decision for her. She must be sensitive or he, whoever the counselor is, to the minor's state of mind and if the minor is ambivalent, has not been able to reach a decision, that must be the first perspective.

* * *

[91] Q. Do your studies indicate whether or not a minor who has received counseling prior to making her abortion decision, whether or not that fact of counseling

has any effect on the likelihood of her subsequent either abortion relief from the procedure or complications from the procedure?

A. It is very difficult to answer, because counseling procedures in different abortion clinics are not standardized, but by and large, I think one could only [92] hypothesize that since the incidence of adverse psychiatric sequelae is indeed very, very small, counseling would have to have a positive effect.

* * *

TRANSCRIPT EXCERPTS OF DR. JAY KATZ

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[96] * * *

Q. Now, Doctor, are you Board certified in any specialty?

A. I am Board certified in psychiatry.

Q. Doctor, do you have any experience in legal matters as well as matters of medicine?

A. Yes. For the last 20 years, I have been on the faculty of the Yale Law School.

Q. Doctor, have you written books, articles and publications, sir?

A. Yes. I have written about 35 articles, including four books on psychoanalysis and law, family law, human experimentation and law and medicine.

Q. Doctor, are you a member of any learned societies?

A. Yes. I was elected two years ago to the Institute of Medicine, which is one of the divisions of the [97] National Academy of Sciences. I am a Fellow of the American Psychiatric Association, American Psychoanalytic Association and many other groups.

Q. Doctor, have you received any outstanding awards which you would like to bring before the Court, sir?

A. Three years ago I received the Isaac Ray Award which is given every year or every other year by the American Psychiatric Association either to a psychiatrist or lawyer for contributions to psychiatry and law.

Q. Doctor, have you undertaken any consultations, sir?

A. I have. I have served on a great many committees. At this point, I am co-chairman of the Connecticut Bar Association Committee on the legal profession and of the American Bar Association of developing a peer review model for lawyers.

I served on the Tuskegee VD-syphilis study appointed by the Secretary of Health, Education and Welfare to look into the experimentation that has gone on for many years with blacks in Alabama and informed consent was a very important aspect of that investigation.

Q. What is your present employment, sir?

A. I am—two thirds of my time I spend as adjunct professor of psychiatry and law at Yale Law School, and one third of my time as training and supervising [98] psychoanalysts of the Western Institute for Psychoanalysis.

* * *

[99] Q. Doctor, have you had a variety of occasions on which to deal with the question of informed consent in your professional work?

A. Yes. Of course, I deal with it constantly in my professional-clinical work and in my consulting work when persons come to see me, asking for information about whether to undergo treatment or not to undergo treatment and for the last 10 years, I have been very much involved in the study of the informed consent process, first in the human experimentation setting and now in both physician-patient and lawyer-client interactions.

Q. Doctor, have you dealt with this topic in the scholarly context as well?

A. Yes. A third of my book on human experimentation is devoted to the informed consent process, and I

am in the process of completing a new case book on disclosure and consent in physician-patient and lawyer-client relationships.

Q. Is that a case book to be used by lawyers and others?

A. Lawyers and medical students, yes.

Q. Where did the idea of informed consent come from? What was the history of its genesis?

* * *

[100] ***The Witness:*** Informed consent is a relatively new doctrine. It was first introduced in a brief opinion in California in *Salgo v. Leland Stanford University Board of Trustees,* where the issue of informed consent was raised for the first time.

It was elaborated upon in great detail in the 1960 opinion, *Natanson v. Kline.* Justice Schroeder, in that opinion, gave the first fairly comprehensive discussion of informed consent, making the point that physicians in the future are under positive duty to make greater disclosure to patients than they had been legally required before, and it was further elaborated in two 1970 opinions, *Canterbury v. Spence,* the opinion of the Washington D.C. Court of Appeals, and *Cobbs v. Grant* of the California Supreme Court.

By Mr. Landsman:

Q. What were the reasons for the genesis of the concept of informed consent in that cusp between medicine and law?

* * *

[101] ***The Witness:*** It increasingly dawned on judges that patients were really very ill-informed about the procedures which physicians recommended them to undertake, and this became particularly clear in the

Natanson v. Kline case where Dr. Kline admitted that he had not given any information to the patient about the serious consequences that might follow a cobalt radiation therapy which was a new therapy at the time, and I think the judges were puzzled to begin with by this behavior and felt that patients had greater rights to information and to participation in the decision-making process.

* * *

[102] Q. As a concept is developed in American medicine and in American law, what is the paradigm of informed consent? Where does this go to? Where is this concept looking?

* * *

The Witness: The paradigm is still very much in a state of development, but I think what the judges are after is to create an atmosphere in which patients have a greater role—have a greater role to play in the medical decision-making process and to gradually begin to define the common law seems to be following in this direction, what are the mutual duties and obligations of physicians and patients in the decision-making process.

* * *

[106] Q. Is there ever a situation when obtaining a patient's informed consent would pose a health risk, sir?

A. Yes, there are situations in which it would. Again, there are studies that seem to indicate that about anywhere from 11 to 17 percent in reported studies of patients [107] do not wish to know a great deal about what is in store for them, and they feel even angry and psychologically traumatized if they are informed and surely, in such situations as acute distress, like myocardial—like heart attacks, when it is important for the patient to be as tranquil as possible to have an extended discussion about consent to various medical

interventions could be detrimental to the patient's welfare.

Q. What techniques and procedures serve to foster informed consent in the exchange between the patient and the physician?

A. I think most important here is the attitude of the physician, namely that he appreciates that the patient is an important participant in the decision-making process.

Q. What would serve to undermine informed consent in situations where it is sought between the patient and the physician, sir?

A. Again, just the other side of the coin of what I have just talked about, bias, prejudice, physician's conviction that only one procedure is indicated and that the patient must choose that procedure, and in the light of all the alternatives available, in a great many medical interventions today, not—and each with its own risks and consequences, not giving a patient an opportunity to have his say in what ought to be done to the [108] patient.

* * *

[110] Q. Now, is the other side of that coin also true that there are times when the physician accedes and should not go further?

A. Exactly.

Q. Now, in terms of frequency of these kinds of situations, in the general context—I know we have sort of been a little specific to abortion, but in the general context, can a physician go ahead once the patient says, "I have heard enough. I know what I want to do. More is not necessary to me"?

A. Sure. In a great many medical situations, it becomes quite clear that the patient wishes to have a

particular procedure performed and that this procedure is [111] professionally indicated, like in an appendectomy and in certain gall bladder operations, and then to go through a detailed explanation of all the risks of anesthesia once it, already having been established that the procedure is necessary and requested by the patient, doesn't really make much sense, and patients will frequently say, "Look, I need this, to your judgment."

Q. We have been a little bit general up to now. I would like to zero in on the abortion context. Would your answer be the same in that exchange between physician and patient?

A. Yes.

* * *

[115] Q. Now, Doctor, considering those three subsections, what will Section 1870.06(B), as it is presently written—what effect will it have on the informed consent process between the physician and the patient—this whole body of material?

A. To my—in my opinion, it will completely undermine it, because taking Section 3 and 4 and 5 as a unit, it is a very one-sided presentation of all the possible risks, physical and psychological, of an abortion. There are no provisions to inform the woman of the possible benefits or to discuss with her the possible benefits of an abortion.

An abortion is a very painful decision to make, and there are assets and liabilities, and the assets are completely left unconsidered.

Secondly, as I have already indicated, too much detail information has to be given even when this information is really unnecessary when the decision for abortion has been made, and it is quite clear the woman has [116]

a clear understanding that she is not just getting rid of a piece of tissue, that she is getting—that she is asking to be unburdened of a fetus that has the eventual potential for life, and what I am concerned about in this one-sided presentation is that the physician-patient relationship will be undermined, that the patient will consider the physician an enemy who is intent on getting her to keep the baby, that she is again, you know, put—placed under duress and, finally, I think it places a tremendous burden on the physician, because many of them will feel under obligation to reveal certain things in a certain way that they feel is neither accurate nor helpful to the patient.

If the physician then takes the way out and says, "Look, by statute, I am compelled to inform you of X, Y and Z—"

Q. I would like to ask—that is the question I would like to get to.

To come back to that, can a doctor who is compelled to obey the mandate of 1870.06(B) palliate the effects you have described by giving additional information, by saying, "I am required by law to do this," and then give other information?

Will that result in problems?

A. No, because the damage is already done, and as I [117] see the informed consent process, that as one first determines what the woman wants and why she wants it, what situation she finds herself in, and after one has that information, then one has to decide not in a general way, because in a general way, one ought to inform every patient of all risks and benefits, but how specific one has to be about particular risks.

Q. Doctor, what impact will Section 1870.06(B) have on the physician in the practice of his profession?

A. I think it will make it very difficult for him to carry out a meaningful informed consent dialogue because it is, as I said, much too detailed on the one hand, and as I also indicated, not detailed enough in terms of exploring with the woman the other side of the picture and also exploring it in an entirely different way. It is not necessary to have to say all the things that the statute requires, but to use his judgment as to the detail in which he has to proceed in order to make sure that the woman understands everything and also what concerns me, is that either physicians, since they are under the threat of criminal sanctions, will feel obligated to say things that otherwise, in their professional judgment, they might not say and also, that they might begin to say to patients, "Look here, this is a requirement of law, and I have to inform you about all these things."

[118] What I am concerned about then is that patients will become confused and not know when is he talking as a professional in his own right and when is he talking in response to what the statute has imposed upon him.

Q. Changing topics slightly, what is therapeutic privilege?

A. Therapeutic privilege is a legal concept which also has been talked about more since the *Natanson v. Kline* opinion in 1960, and if a patient makes the allegation that he or she has not been sufficiently informed about a procedure, an informed consent has not been obtained, the doctor in defense can assert that it was not in the patient's therapeutic interest to be informed about X, Y or Z.

Q. What purpose, if any, does it serve the physician in the context of informed consent?

* * *

The Witness: It gives the physician professional latitude to at times not follow the mandate of the *Natanson* and *Canterbury* reasoning to fully inform, because [119] the patient's psychological and also physical condition may be adversely affected by this information.

By Mr. Landsman:

Q. Doctor, is there any need for therapeutic privilege in the abortion informed consent?

A. I think there is.

Q Look again at 1870.06(B), sir. Under its strictures, would a physician be able to exercise therapeutic privilege?

* * *

The Witness: Yes, in a number of ways. For example, in cases of incest and pregnancy, rape and pregnancy, or in situations where a youngster who has gotten pregnant being somewhat ambivalent about it has decided to follow the wishes of the parents to have an abortion.

Under these kinds of circumstances, to really go through a detailed explanation of [120] what the fetus might look like at the time of removal, I think, would be extremely traumatic to the persons involved.

By Mr. Landsman:

Q. Doctor, do you find any therapeutic privilege available in 1870.06(B)?

A. I do not.

Q. What effect will the absence of therapeutic privilege have here?

* * *

The Witness: I think it unnecessarily will traumatize a certain portion of women, though one cannot be sure

who will and who will not be traumatized, but there is no reason to even take that chance.

Why take it, then?

* * *

[121] Q. Are there statutes or ordinances, to your knowledge, sir, which utilize criminal sanctions to enforce rules involving the therapeutic interaction between the patient and the physician? Not just informed consent, but the relation between physician and patient more expansively.

A. The only statute to that effect that I know deals with such issues as the reporting of gunshot wounds.

* * *

STIPULATION OF COUNSEL

VOLUME IV

[140] * * *

Mr. Hawley: At this time, Your Honor, we would like to put a brief stipulation on the record that the City and I believe counsel for Intervenors had joined in and that goes to the fact that there are five hospitals in the City of Akron.

Those five are Akron City Hospital, Akron General Medical Center, St. Thomas Hospital, Akron Children's Hospital, and the Edwin Shaw Hospital and that there have been no abortions performed within the last year at Akron Children's Hospital, St. Thomas Hospital, or at Edwin Shaw Hospital.

[141] ***Mr. Bickett:*** Your Honor, we would enter into that stipulation at this time.

Mr. Umbaugh: That is correct, Your Honor.

The Court: All right. The Court shall receive the stipulation.

* * *

TRANSCRIPT EXCERPTS OF DR. CHRISTOPHER TIETZE

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[143] * * *

Q. Now, what has your work, especially in the past 10 to 15 years, involved, sir? What have you been involved in?

A. Since I have come to New York, NCMH and later the Population Council, I have been concerned with the evaluation of methods of fertility regulations.

In the early years, we were primarily concerned with the evaluation of the effectiveness, acceptability and safety of methods of contraceptive methods, especially of intrauterine devices, and I was involved in a major study of intrauterine devices, which included about 45,000 patients who we followed over protracted periods of time up to six years.

Over the last 10 years or since—really since 1970, I have been primarily concerned with the evaluation of the demographic and public health aspects of induced [144] abortion on a worldwide basis.

Q. Doctor, have you done any consulting work in the same field?

A. I have done a variety of consulting work. My major involvement has been with the World Health Organization where I have participated in the two scientific groups on abortions that they have had, the first one, I believe, in 1969 and the second one in 1977.

I also serve as a Chairman of the Steering Committee of the Task Force on sequelae and complications of induced abortion which has sponsored a number of studies in a number of countries.

Then, for some years, I was a member of the Advisory Committee on Obstetrics and Gynecology to the Food and Drug Administration. At that time, they were and still are concerned with evaluation of contraceptives and I have drafted some of their reports.

Q. Doctor, have you had publications in this same area as well?

A. In the course of my life, beginning in 1931, I have published well over 200 publications in general—in total, mainly in the area of human fertility and its regulation, including more than 60 articles on abortion published in scientific journals, both here and abroad.

Q. Has your work been cited to by the United States [145] Supreme Court in the case of *Roe v. Wade*?

A. Yes, it has.

* * *

[150] Q. Doctor, I would like to turn your attention now to a separate question. Across the United States in percentage of total abortions performed, what is the demand for second trimester abortions?

A. At the present time, or rather 1976, which is the last year for which we have data, we had about just slightly less than 10 percent second trimester abortions down from about 20 percent five years earlier.

Q. If you know, from the information that you have analyzed, who are the women—what category, types of women who seek second trimester abortions?

A. Well, firstly, very young women. Secondly, poor women. Very often, women of minority groups, and because of the association of both poverty and minority status with high birth rate, you also find a somewhat higher proportion of late abortions among the abortions to women of the child-bearing period and that is true for all countries.

[151] Q. If you have analyzed this problem, why is it that these groups of women seek second trimester abortions later than other groups?

A. Well, as far as the very young are concerned, they sometimes are not yet regularly menstruating. They don't know the symptoms of pregnancy. Once they suspect they are pregnant, they may hope it will go away; it may not be true. They practice what psychologists call denial. They are afraid to talk to their elders. In some cases, there may be requirements for parental consent. They may not have the money to pay for their abortion and so forth.

As far as the poor are concerned, they are not able to, as better off people, to manipulate the medical care system, and they get—it takes them longer to go to the right place, to the right person and to get service.

* * *

[157] Q. Doctor, are you familiar with statistics concerning abortion mortality rates in England, sir?

A. Yes, sir.

Q. How do those statistics compare with those of the United States, sir?

A. In overall, their mortality has been higher in England, although it is coming down now, and for the last few years, the mortality for curettage procedures in the first trimester is only slightly higher than the United States.

Q. Has any analysis been made of why the rate of mortality is higher in the United Kingdom that the United States?

A. Well, this has been studied a great deal both by our colleagues and the United Kingdom, and on this side

of the Atlantic, there are two major reasons involved there.

One is--three, rather.

One is that in general, abortions are performed later in the United Kingdom than in the United States, later in pregnancy.

Second, that at least in the early years, they used hysterotomy, which is a major surgical procedure, in a substantial proportion of cases which has declined, but [158] it is still much higher than in the United States, and thirdly, they combine--this did combine in an appreciable percentage of cases the abortion operation with a sterilizing procedure. That, too, has become less frequent, but it was certainly an important factor in the early years.

Q. Was there any other cause for delay built into the English approach to providing abortion?

A. Any other than what?

Q. Any cause for delay not present in the United States?

A. Well, very much so. The English system is quite cumbersome. The woman first has to go to her general practitioner with whom she is registered under the National Health Survey, and then he has to refer her to a gynecologist to do the operation, and if either the practitioner or the gynecologist feels that she doesn't meet the conditions of the Act under which abortion is permissible, she may have to go to another one, and actually, she needs two signatures, a concurrent opinion of two doctors before she can have the abortion, and that causes delay of several weeks on the average.

Q. Doctor, does that delay increase mortality rates?

A. In the light of what I said before, I would say yes, about 50 percent for each week that elapses.

* * *

[*Redirect Examination by Mr. Landsman:*]

[179] Q. I just have one question, Doctor. On cross-examination you mentioned that there was a study conducted concerning comparison between the safety of clinical procedures of abortion and hospital procedures of abortion.

[180] [Q.] Could you just tell the Court what that study demonstrates?

A. This was a very interesting study. It was undertaken because some people claimed that the mortality associated with outpatient procedures, particularly procedures in clinics, was much higher than mortality after abortion in hospital settings.

So, Dr. Grimes, G-r-i-m-e-s, David, and his associates tested this on the basis of '74-75 data. They took, as a denominator, all abortions in clinics and all abortions virtually all of which are first trimester abortions and all first trimester abortions in hospitals, and they found that the mortality of the hospital abortions was about two per 100,000 and of the clinic abortions was about one per 100,000.

Then they eliminated from the denominator and numerator two classes of women: one of women who had a prior medical complication which could increase the risk of the procedure and, second, all cases where the sterilizing procedure was carried out at the same time and after that—and such cases occurred only in the hospital material.

After that was done, the risk to life was exactly the same, one per 100,000 in both series.

* * *

TRANSCRIPT EXCERPTS OF RAY KAPPER

VOLUME IV

[*Direct Examination by Mr. Hawley:*]

[183] * * *

Q. Are you a member of the Akron City Council?

A. Yes.

Q. And are you a particular officer of that Council?

A. Yes.

Q. Which office do you hold, sir?

A. President.

Q. How long have you been a member of the Council?

A. Approximately 11 years.

Q. How long have you been Council President?

A. Two—two and a half years.

Q. Mr. Kapper, were you the sponsor of the abortion ordinance that was introduced in Council in October of [184] 1977?

* * *

The Witness: One of the sponsors.

By Mr. Hawley:

Q. Were you the first sponsor of the ordinance?

A. Well, I asked the Law Department to draft it.

Q. Well, my question was: Were you identified as a sponsor prior to any of the other sponsors of the ordinance?

A. Yes.

Q. Were you also a sponsor of the final version of the ordinance passed in February of 1978?

A. One of the five at that time.

* * *

[187] Q. I would like to know if you talked to anybody, for example, from the Summit County Medical Society regarding their efforts to look into the activities of these clinics prior to your vote on the ordinance?

A. I believe—

The Court: Prior to the time he voted on the ordinance?

Mr. Hawley: Yes.

The Court: Okay.

The Witness: Prior to the time I voted on this final passage?

By Mr. Hawley:

Q. Yes.

A. Yes. Not of introducing it, but passing it, yes.

Q. No conversation prior to introducing it?

* * *

The Witness: Certainly I had conversation with the Health Department.

By Mr. Hawley:

Q. And with officials of the Summit County Medical Society?

[188] A. No.

Q. Prior to the passage of the ordinance, had you visited any of the three clinics in Akron?

A. No.

* * *

[191] Q. Were you familiar prior to the introduction

of the ordinance with what kinds of procedures were available to perform second trimester abortions?

* * *

The Witness: No. The answer would be no.

* * *

[193] Q. Prior to your vote in favor of the ordinance, had you seen copies of any of the informed consent documents which the clinics, the three Akron clinics, provide to their patients?

A. No, I hadn't seen them. I think I indicated earlier I had never been in one of the clinics, only had talked to employees that worked in those clinics.

* * *

[196] Q. To your knowledge, Mr. Kapper, are there any public hospitals or any hospitals owned or operated by the City of Akron?

A. Not presently.

[197] Q. Are there any surgical health facilities of any type owned or operated by the City of Akron?

A. Not presently.

Q. Do you know of any plans for any?

A. Well, not presently.

* * *

[199] Q. My question was: Does it happen and how often does it happen that the City of Akron—that ordinances have been passed subsequent to advice from the Law Department that they are unconstitutional?

* * *

The Witness: Many times.

By Mr. Hawley:

Q. In particular, what instances?

* * *

The Witness: Not offhand, Your Honor. I will be glad to go back, but there have—one I think of was on a—the Law Director, Mr. Baird at that time—there was legislation introduced on vacant buildings [200] as well as vacant gas stations and that and we had passed a law that if they weren't put back into some use within 90 days, they were to be torn down. His advice to us was it was unconstitutional, but we proceeded to pass that. It has not been tested in the courts here in Akron, and we have followed through with that law.

* * *

TRANSCRIPT EXCERPTS OF DR. FREDERICK ROBBINS

VOLUME V

[4] * * *

[*Direct Examination*] *By Ms. Leitzer:*

Q. Please state your name and address for the record.

A. Frederick C. Robbins, 2467 Guilford Road, Cleveland Heights, Ohio.

Q. What is your current position, Dr. Robbins?

A. Dean of Case Western Reserve University School of Medicine. I also hold the rank of Professor of Pediatrics and of Community Health.

* * *

[7] Q. Have you received any awards or honors?

A. I have received some, the most notable of which is the Nobel Prize for Physiology in Medicine in 1954.

* * *

[11] Q. Now could you please turn your attention to the definition section of the Statute 1870.01?

I am going to be referring to Section C in the definition of unborn child, a term which is used throughout the Statute.

Is the term "unborn child" generally accepted in medical terminology?

A. It is not generaly used.

Q. Now I am going to 1870.06, informed consent, in the Ordinance.

The first clause of Subsection (B)(3) states:

"That the unborn child is a human life from the moment of conception . . . ."

Is that a medically accurate statement?

A. That is not a term that scientists or medical people would be able to define.

That does not have any biological meaning as such. It is, in my opinion, it is a matter of religion or moral judgment, not a matter of scientific judgment.

Q. Is there any scientific or medical basis for that statement?

A. None.

Q. Doctor, if you were required by law to comply with the provision of 1870.06(B)(3), that is to state to each patient that the unborn child is a human life from the moment of [12] conception; would you comply?

A. Not willingly, no.

Q. Why not?

A. I find that violates my principles, my moral and ethical concerns.

* * *

TRANSCRIPT EXCERPTS OF DR. CARL WILLIAM KECK

VOLUME V

[*Direct Examination by Mr. Hawley:*]

[40] * * *

Q. Dr. Keck, please state your full name for the record.

A. My name is Dr. Carl William Keck.

Q. How are you presently employed, sir?

A. I am employed by the City of Akron as the Director of Health.

Q. How long have you been the Director of Health in Akron?

A. Approximately two and a half years, since beginning in 1976.

Q. You are a Defendant in this lawsuit?

A. Yes, indeed.

* * *

[*Cross-Examination by Mr. Destro:*]

[56] Q. To your knowledge, are there any clinics run at the Morley Health Center wherein a minor between the ages of eleven and eighteen would come without a parent?

A. Yes. The prenatal clinic is one; venereal disease control clinic is another.

Q. Are there any others besides that, to your knowledge?

A. I am really not sure. I cannot tell you for sure.

Q. Does the prenatal clinic treat minors under the age of eighteen without parental consent?

A. So far as I know, we do not have a signed parental consent form that deals with that age group, correct.

Q. Do you treat minors at the prenatal clinic without notifying parents?

[57] A. I do not believe we do. Obviously if—I think in most cases the people are pregnant, the family knows it. Particularly when they are getting prenatal care.

I am not aware of any requirement for parental consent for us to deal with that pregnancy.

* * *

TRANSCRIPT EXCERPTS OF DR. THOMAS KERENYI

VOLUME V

[*Direct Examination by Mr. Bickett:*]

[69] * * *

Q. What is your present position and what are your present responsibilities?

A. Chief of Obstetrics in the Department of Obstetrics and Gynecology at Mt. Sinai and also in charge of the abortion unit.

Q. Do you have any academic position?

A. Academic, Professor of Obstetrics and Gynecology.

Q. What is your experience in obstetrics and gynecology?

A. Seventeen years, all in obstetrics and gynecology. The past five years have been in perinatology.

* * *

[*Direct Examination by Mr. Landsman:*]

[74] Q. Have you done any research on why women delay in getting abortion?

A. We did. We interviewed some four hundred late aborters, all that came for second trimester abortions. We were trying to find out what makes them delay.

Q. What were your conclusions in that?

A. Somewhat disappointing in the sense we never found one clear answer. Our primary conclusion was that this is one of human nature failing, primarily procrastination.

When we come to a difficult decision, they freeze into inaction.

Q. Who are the women that face these problems?

A. We found mostly the very young, young teenagers; the very [75] poor, and the uneducated. They were the very women who are least capable of coping with the pregnancy at any stage.

Q. What is the medical danger in delay, sir?

A. It has been established that the later you do an abortion, the greater complication rate you are likely to encounter.

Q. Would that apply in these kinds of—

A. That applies at any stage. The later you do it, the more likely that complications will happen.

This carries through all of pregnancy. The later the delivery, the likelier the complications as well.

Q. Is it medically necessary that all second trimester abortions be performed in a hospital?

A. Not at all.

Q. At what point is a hospital presently advisable, given the techniques that we have available?

A. In my opinion that comes in about eighteen weeks.

Q. Why is that, sir?

A. Because I think at that point, the potential complication by the nature of it would best be handled in an institution which has an operating room available at all times; a more sophisticated blood bank than you could manage outside of an institution.

Q. Is there any greater risk to maternal health with respect to second trimester, if they were performed in clinics rather than hospitals?

[76] A. No.

Q. What are the costs of doing second trimester abortions in a hospital rather than clinics?

A. Once you enter a hospital, the cost would jump inevitably.

* * *

[*Cross-Examination by Mr. Dandrea:*]

[91] Q. Given the possibility of who might do counseling, a layman or woman or a physician; would it be your testimony that in all instances the better practice is, it should be done by a physician?

A. That is what we used to think and we found out that patients—or woman counselors without necessarily medical degrees usually end up doing a much better job than we do.

Q. With respect also to medical areas of competence?

A. If they get to an area of questionable medical competence, they can certainly stop there and call us in.

[92] Most patients do not want this, and they feel imposed upon if we jam it down their throats.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[102] Q. * * * You indicated on direct examination, I believe—and correct me if I am wrong—that in your judgment, 18 weeks was the approximate cutoff for the need for a hospital abortion. That is, after 18 weeks it would be desirable to be done in a hospital. Prior to that, it was not necessary.

Would that also hold true for minors?

A. I do not see the difference. A pregnant woman is a pregnant woman.

Q. If a minor had a complication at 16, 17 weeks; is it not true that hospitals are more equipped physically to handle those complications than the typical clinic?

A. There is nothing magical about the hospital.

Q. My question is: Which would be more capable equipmentwise to deal with the complication, sir?

A. Depending upon the complication, in a hospital you may [103] have a difficult time getting into the operating room because two brain surgical procedures are being scheduled. If you are standing in line with a perforation, you may wait several hours.

If you adequately designed facilities, you may get into the operating room quicker and handle it and nip it in the bud.

If you stand in the operating room corridor for 25 operating—

Q. Your answer concerning a clinic includes a clinic with an operating room?

A. For complications, depending upon the nature of it, an operating room—it happens to be an operating room in a hospital. It may be called a treatment room in an abortion clinic, freestanding.

My point is, depending upon the nature of the complication, you have to be properly equipped. In my judgment—and probably if you ask ten physicians you will get ten different answers—in my judgment, about 18 weeks is where you begin to run into the type of complications. It is hard to care for them outside of the hospital.

* * *

TRANSCRIPT EXCERPTS OF DR. ROBERT BLISS

VOLUME V

[*Direct Examination by Mr. Hawley:*]

[108] * * *

Q. * * * Are you paid for the abortion services which you perform at the Akron Women's Clinic?

A. Yes, I am.

Q. How are you paid?

A. I am paid per procedure and my expenses are paid to come to Akron and to get back.

* * *

[114] Q. If I could call your attention, Dr. Bliss, to Section 1870.07, the next section, entitled "Waiting."; if you were required, Dr. Bliss, to travel to Akron a day in advance of the day when you were scheduled to do procedures in order to give the information required in Section 1870.06, what would you do?

A. Well again, I would comply with the law, if the law required me to do so. However, it would be a great inconvenience to me.

Certainly this would narrow down my chances for being able to satisfy the requirements of the Akron Clinic since there would be fewer days that I would be able to help them out.

There would also be an additional cost to not only travel to Akron, but the cost of my time in giving an extra day to see the same number of patients.

Q. You would charge the Clinic more?

A. I would have to charge the Clinic more.

* * *

TRANSCRIPT EXCERPTS OF FERN CROSSMAN

VOLUME V

[*Direct Examination by Ms. Roberts:*]

[147] * * *

Q. Where are you employed, Ms. Crossman?

A. Summit County Welfare.

Q. In what capacity do you work?

A. I am Administrative Assistant in the Medical Department.

Q. Could you briefly describe your duties and responsibilities as an Administrative Assistant?

A. My field is health. I serve as liaison between providers, providing health information, counseling when necessary, hoping that they are able to talk about their problems.

* * *

[151] Q. Ms. Crossman, now the counseling, the pregnancy counseling you provide to clients; what does this include?

A. Okay. When she comes to me, she, at this point, feels she needs to talk with somebody.

So the first thing we have to establish is that she, indeed, is pregnant. Once that has been established, then we have to talk about the alternatives that are available to her.

There are a number. The fact that we have an agency where we work, where the need for dependent children means, of course, she could continue with the pregnancy and get help through ADC.

Another one would be, she could carry it and put it up for adoption, or if she indicated that termination of

the pregnancy is what she wanted, we would discuss that too.

All of those alternatives must be explored and the opportunity to talk about it and the opportunity to talk about the family as a whole. If she has not been able to talk to anyone in her family, a young person coming to me, I explain she should share some of that with her family.

In a subsequent counseling period, very often the mother will come in and she will have had a chance to talk with her mother.

[152] Then we are able to achieve two goals. One is that she is able to deal with the pregnancy and the other, she is able to reconcile herself with her family.

So then, from there on, we go whichever way she wants to go.

Q. But in situations where the client feels that she cannot or is not willing to share that information with her parents, then you do not reveal that information to her parents yourself?

A. Oh, no. Sometimes you will have a mother who suspects that her child is pregnant. She may call you and ask you and all you can do in a situation like that is tell her that she will have to talk to her daughter about it.

Because we cannot give out any information like that. We would be in violation.

Q. Ms. Crossman, you mentioned as one of the alternatives that is discussed with a client under these circumstances the option of termination of the pregnancy.

A. Yes.

Q. Would this be discussed also with young women under the age of eighteen?

A. Oh, yes. It is kind of interesting because of the fact we are an agency dealing with unwed mothers.

If you have an unwed mother who has one or two children, she is well aware of the stresses and strains. She knows how hard it is economically to deal with it.

* * *

[155] Q. Ms. Crossman, do you, in your referrals to facilities for termination of abortions, do you make referrals to the Akron clinics and the Akron Center for Reproductive Health, Women's Clinic, or Women's Care?

A. All three.

Q. Are you familiar with these clinics?

A. Yes, I have visited each one.

Q. Are you familiar with their staff, their procedures?

A. Yes.

* * *

[*Cross-Examination by Mr. Destro:*]

[169] Q. How many have had that problem, such as an abusive parent or one who impregnated them by incest?

A. Those are usually referred to us by protective services. We might refer them to Children's Services Board as well.

At that point, I would not continue.

Q. How many have you had, that is basically my question. How many have you seen? How many clients have you seen with those problems who were minors?

A. This month?

Q. Fine.

A. I had one this month.

Q. What was her problem?

A. Do I have to answer that?

The Court: You are not talking about any person. You are talking in generalities.

Do not disclose any names.

The Witness: Well, this was a girl of—

The Court: General categories. Was it incest, rape?

The Witness: It was incest.

* * *

TRANSCRIPT EXCERPTS OF KATHLEEN GOTSHALL

VOLUME VI

[*Direct Examination by Mr. Bickett:*]

[19] * * *

Q. Do you have any policy concerning a refund of any of this amount, should the abortion procedure not be completed at your clinic?

A. Yes, we do.

* * *

Q. Ma'am, is the doctor paid at your clinic per procedure, per hour, or per week?

A. Per procedure.

[20] Q. If the doctor decides not to proceed with an abortion, for whatever reason, emotional, medical, or she is too far along gestationally, whatever it is, does he receive the fee as if he had performed the abortion procedure?

A. No, he does not.

Q. Does he receive any fee at all?

A. No, he does not.

Q. Ma'am, in the complaint in this action, there were allegations made that should this Ordinance go into effect, that your clinic would suffer economic loss.

Would you please describe to the Court, if you can, or if you know, what the basis for those allegations are?

A. I know for a fact that most of the social service agencies that refer patients to us, would no longer refer those patients to us. I think we have had testimony to that effect.

A second consideration is, if the Ordinance did pass, it would be to the detriment of the clinic and it would be a fact that we would have to pay for the physician's services, for a physician to come in and do counseling and witness the consent form 24 hours ahead of time. Those are the two major repercussions that I can see.

Q. That would be summed up as additional physician time and possible patient loss?

A. Correct.

[21] Q. Are there any other economic harms which you may suffer other than those two categories?

A. The physician's time, which would also include staff time, additional staff time.

Q. So there would be three then; possible loss of patients, additional physician time, and additional staff time?

A. That I can foresee right now, yes.

* * *

TRANSCRIPT EXCERPTS OF PATRICIA K. BLACK

VOLUME VI

[*Direct Examination by Mr. Destro:*]

[53] * * *

Q. If Donna were to become pregnant and were to seek an abortion, would you wish to be notified?

A. Yes, I would.

Q. Would you state your reasons for desiring to be so notified for the Court?

A. Because I feel that Donna would lack maturity to make a decision on her own. She couldn't possibly, I don't feel, be capable of considering all of the side effects of the [54] situation.

I know that it would probably hinder her physically, mentally, and spiritually, and she couldn't possibly consider all the sides on her own.

* * *

[*Cross-Examination by Ms. Leitzer:*]

[55] Q. If Donna informed you that she was pregnant, how would you consult her? What would you say to her if she came home one day and you observed that she was upset and you found out that she was pregnant; what would you say to [56] her?

A. I would try to comfort her.

Q. What would you say to her about her options; would you discuss those options with her?

A. I personally wouldn't consider an abortion.

Q. Under no circumstances?

A. No.

* * *

TRANSCRIPT EXCERPTS OF NORMA GOLDBERGER

VOLUME VI

[*Direct Examination by Mr. Bickett:*]

[96] * * *

Q. Ma'am, are your doctors paid by the Clinic?

A. Yes, sir.

* * *

[97] Q. If a doctor at some point refuses to perform an abortion on a patient for medical reasons, emotional reasons, whatever the reasons are, does he receive the fee as if he would have performed the abortion?

A. No, sir.

Q. Does he receive any fee?

A. No, sir.

* * *

[116] Q. Ma'am, in the complaint, there were allegations made that your Clinic would suffer economic loss should this Ordinance go into effect.

Are you aware of whether, of what the basis of those allegations are?

A. Yes, sir.

Q. What is the basis for those allegations, in your opinion?

A. There are several different factors of which I need to mention.

The first major concern is the requirement of two trips to the facility. Now, out of surveying 200 of our patients, we find only 50 are from the Akron area and 150 have traveled as far away as Columbus, West Virginia, Elyria and Lorain.

Now, during the course of gathering information for this, we did ask twenty-five patients who were from out

of town, whether this two trip requirement would affect them in their decision to come to our Clinic. More than half [117] of these patients indicated to us that they would not make the trip twice from their home to Akron, but instead would go to the clinic in Cleveland if the Ordinance were to be passed.

Other patients who lived in the City indicated, because of the extra cost of not having to work a work day, that it might make them choose a clinic in another city where they didn't have to make two trips.

Since we are the clinic that does abortions further along than any other clinic in the area, one of the problems we would foresee would be that the rejected patients in these clinics, the ones in this fourteen week LMP period of time, the ones who are rejected on Friday afternoons, if they would come to us the next day, on Saturday for the counseling, the next time that we could see them would be the following Wednesday or Thursday, depending upon the doctor availability. So, that might make them too far along to have a first trimester abortion.

We talked to Planned Parenthood and the Welfare Department who, as I said before, do refer the bulk of our patients to us, and most of these referral agencies say that they will be reluctant to refer patients to our Clinic, not only because of the two trips that are necessary by the Ordinance, but because of the harassing nature of the fetal description which they feel is very unsympathetic [118] to the patients.

In addition, I have discussed with the doctors the impact this would have on them and the physicians that we have available to us on an emergency basis, specifically, the physician from Cincinnati, said that it will be difficult, if not impossible, for him to make a trip here to do the counseling and not do any procedures on that

day and then come back another day. This will be a waste of his time. He does like to have some time off.

Of course, we have another doctor who just changed his position at one of the hospitals in town and in changing his position with that hospital, he has cut down on the time that he is available at our Clinic. He has indicated that he cannot give us more time. In fact, he has to give us less time because of his new commitment.

We have another doctor that said that he would, if he had to tell patients that this was a human life which began from the moment of conception, that he would quit the facility before complying with that.

Another doctor said that if he had to show up and not do procedures, that he would charge us for that, but he didn't know how much.

* * *

[121] Q. Do you know why the information on the fetus would be considered harassment?

A. Yes, because it is information of a highly emotional nature, information which is designed to dissuade women from their choice. It would be as if I were going to a dentist if I had a cavity in my tooth, and the dentist said, "Let me explain how this cavity happened." What I would want to happen is to have my tooth fixed and not have explained [122] to me the nature of the cavity or how it happened.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[133] Q. Should a minor child wish a parent to accompany her into counseling, yet the rest of the group or some members of the group oppose that, will the parent participate in the counseling with the minor?

A. You are asking for an exception and I am trying to think of what we do under such exceptional circumstances.

We feel that the group is specifically important for minors and we encourage certainly minors to be there just to see that abortions do happen to women in their 40's as do women in their teens.

Q. My question is: In the circumstances where a minor comes into your Clinic with a parent and wishes to go through the counseling with a parent and yet some member or members of the group would oppose that, would then the minor be separated from her parents or parent, nonetheless?

A. Yes, they would be separated. Then they would be allowed to get together again with a counselor to talk about the topics on anything discussed.

* * *

[137] Q. When it's deemed desirable for that minor to receive counseling or, I am sorry, a tranquilizer, how is that conveyed to the doctor?

A. The doctor has a standing order which indicates that a patient, once she has signed the informal consent, has indicated that she is firm in her decision to have the abortion and does not present any other immediate medical problems or any evidence that she has taken any drugs before coming into the Clinic, may be offered 10 mg. of Librium.

Q. So if the Clinic personnel determine that she meets that criteria, it does not—not where the doctor individually advises it, but you do give that tranquilizer to her and it's just policy?

A. It's by his standing order.

* * *

[139] A. Typically, we enter into a discussion of the decision of the patient towards abortion, and this

certainly includes what she feels is best in her conscience and for her life.

* * *

TRANSCRIPT EXCERPTS OF DR. "C"

VOLUME VII

[*Direct Examination by Mr. Bickett:*]

[5] * * *

Q. And could you describe to the Court the contract or financial arrangements you have with the Akron Women's Clinic?

A. I am paid on a per patient basis.

* * *

[6] Q. When you first come in contact with the patient, what do you do with the patient?

A. Typically I go into the room where the patient is located, then I introduce myself. I ask the patient if she has any questions. We go ahead and do a pelvic exam, to ascertain the size of the cervix.

[7] I again ask her if she has any questions and go ahead and mechanically do the procedure.

Then, you know, if everything went smoothly, just tell her, "Do you still have any questions? If you have any problems, definitely get in contact with us."

Then I like to see her in the recovery room and hopefully at the three week follow-up, we will see her again for birth control and a complete pelvic exam to ascertain we have not had any problems.

Q. Do you engage in counselling of any type with the typical patient?

A. Through the clinic, no.

Q. Is there a distinction between your private patients and the clinic patients?

A. Yes.

* * *

[30] Q. Doctor, once again going through 1870.06B, Sub-divisions 1 through 7, I would like to go through the sections this time, Doctor, but keeping in mind not whether the information is typically given, but whether you consider the information relevant in making an informed decision about whether or not to have an abortion.

A. Okay.

Q. First of all, Doctor, do you think it is relevant to making that informed decision about whether or not to have an abortion, number one?

A. It is relevant if she is pregnant. She is there, it is relevant. If she is not pregnant, we do not do the abortion.

Q. Okay. Could I refer you to Number 2 with that question in mind?

A. The question, again, with regards to Number 2?

Q. Whether or not that information would be relevant to the individual making an informed decision about whether or not to have an abortion.

A. It could be relevant.

[31] Q. Okay.

A. I mean, if I tell her she's 24 weeks, she has to make a decision, doesn't she?

Q. Okay. Doctor, referring you now to Number 3, once again, I will sub-divide this section as two compound statements.

Would it be relevant to make a decision whether or not to have an abortion that is the statement that the unborn child is a human life from the moment of conception?

A. That is a theological, philosophical question, I do not think it is relevant, no. She wouldn't be there—

Q. Okay. The second part, Doctor, is that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members; would that be relevant to making an informed decision about whether or not to have an abortion?

A. Not in my thinking, no.

Q. Doctor, referring you now to Number 4, again with the same question in mind, would that information be relevant to an individual in making an informed decision about whether or not to have an abortion?

A. Yes.

[32] Q. Referring you to Number 5, Doctor, once again I sub-divide this into sections, as it is a compound statement.

First of all, is the statement, "abortion is a major surgical procedure," one which is relevant for an individual making an informed decision about whether or not to have an abortion?

A. I do not think dilatation and curettage is a major surgical procedure, so, no, that is not relevant.

Q. Doctor, referring you to the next part of that, "Abortions can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage"; would that information be relevant to the individual making an informed decision about whether or not to have an abortion?

A. I think it should be also included if she takes that pregnancy her chance of having those grow tenfold.

Q. Would the information included in that statement be relevant?

A. Yes; again, it is covered in the informed consent.

Q. Would the statement "Any existing psychological problems she may have," be relevant to an individual making an informed decision about whether or not to have an abortion?

A. If she would have serious emotional, psychological problems, it might be relevant, but the pregnancy can certainly worsen those conditions.

[33] Q. Doctor, would the statement, "Can result in severe emotional disturbances" be relevant to an individual making an informed decision about whether or not to have an abortion?

A. It could be.

Q. Doctor, would the information that numerous public and private agencies and services are available to provide birth control information be relevant to an individual making an informed decision about whether or not to have an abortion?

A. It could be relevant, but she's already at the clinic and she knows what the clinic is.

Q. Okay. Doctor, referring you now to the Number 7, the last statement in that group, "That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption;" would that information or statement be relevant to an individual making an informed decision about whether or not to have an abortion?

A. Right, if she has chosen not to have the abortion, that is very relevant information.

Q. Would it be relevant in making the decision?

A. Again, if she was already at the clinic she's there for one purpose. She's already gone through all the steps to get to the clinic. She's already made her own decisions as to what to do with that pregnancy.

[34] Q. Are you saying, Doctor, then when an individual comes to the clinic she has made up her mind to have the abortion?

A. Sure; when you go to a bar, you go there to drink.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[43] Q. Doctor, have you, yourself, within the clinic facilities, ever particularly authorized a minor to receive a tranquillizer of any kind prior to that minor receiving counselling?

A. No.

Q. Have you stated any policies to the clinic personnel concerning the issuance of tranquillizers to minors?

A. It is a general policy of the clnic that those who wish it can have a tranquillizer.

Q. Does that include minors, sir?

A. To the best of my knowledge.

* * *

[46] Q. When you consult with a minor, who has come in to your private office for an abortion, do you also consult with her parents at the same time, at that half hour or 45 minute interval?

A. They're sitting side-by-side.

Q. You do not make an effort to separate them and talk to her alone?

A. No, unless she so desires.

Q. In your private practice, in that 30 to 45 minutes, do you discuss, with the parents and/or the child, the fact that you had testified to earlier, that abortions are a bit more difficult or the medical procedure is a little bit harder?

A. The technical procedure? The technical procedure, yes.

Q. The fact it is more difficult on a minor, do you discuss that in your private practice with the child?

A. Sure, I get into rigidity of the cervix and recommend the Laminaria to them.

Q. What does that mean?

A. Laminaria?

Q. Yes.

A. Laminaria is a Japanese seaweed that is inserted into the cervix five or ten hours before the procedure, and it softens and dilates the cervix.

Q. You also often recommend that to a minor prior to undergoing an abortion in your office?

A. Yes.

[47] Q. Do you make such recommendations to a patient at the clinic?

A. No, there aren't any there—they're already there, I am just the last man.

* * *

TRANSCRIPT EXCERPTS OF DR. FRANCOIS SEGUIN

VOLUME VII

[*Direct Examination by Mr. Destro:*]

[49] * * *

Q. Do you have any children?

A. I have four children.

Q. And what are their age ranges?

A. 15, through 8.

Q. Do you have any children of childbearing age?

A. Yes, I have one daughter who is 14½.

Q. Do you have any other children who will be of childbearing age in the future?

A. Yes, I have another daughter.

Q. Did you seek to become an intervenor in this action, Doctor?

A. Yes, I did.

Q. And what were your reasons for seeking such intervention?

A. My reasons were, basically, as a parent with a child who is in the childbearing age group and there was a possibility, even though we brought her up to the contrary, she may become pregnant [50] outside of marriage, despite our counselling and so on. If such a situation were to arise, I felt it was of utmost importance that I, as a parent, would be knowledgeable of such a fact, so I may properly counsel my own daughter. My own moral belief aside, I do not believe in abortion to begin with, but even that aside, even as a parent, I think for the support of my child, who I do not think at 14, 15 or 16 can make a mature judgment as to what

ought to be done in such a situation, that they need my guidance as a parent.

* * *

[51] Q. In your own practice, Doctor, do you treat minors under the age of 18 without parental notice or consent?

A. No.

Q. Are there reasons for this policy that you have?

A. I think the basic reason for this policy is that, frequently without the parental consent children will not follow through on treatment. They will not always follow your advice. Even the older child who is 15 or 16, who I may see for a specific illness, I may advise they ought to stay home for three days in bed or stay home or so on; my experience is children, particularly school age, high school, they are involved with many things. There are football games, they do not want to miss this, particular situations.

Unless the parent is aware of what you have advised the child, they will do many things to get around so they can do their thing.

Even in the office they often frequently say, "Gee, Doctor, I really have to stay home three days? We have a big football game two days from now." They try to convince me to go against my own principles.

I think it is very important the parent is informed.

Recent example, last Saturday I saw a 21-year-old boy, who [52] has a condition, it was rather important he stay home and stay on bed rest for the next 48 hours. I asked him to return at that time for follow-up. Just on a suspicion, I called the father the next morning and the child had gone to work, so I had to have his father

go down and get him home from work, which was really detrimental to his condition.

* * *

Q. * * * Do you, in your own practice, make any exceptions to this rule for specific kinds of illnesses, say pregnancy or venereal disease, for example?

A. Generally in the case of pregnancy or venereal disease, if it is a child under the age of 18, I will tell the child that I will inform the parent of the situation. If it is a cause of venereal disease I also let them know I have to inform the local health department so that this is followed up.

* * *

Q. With regard to minors under the age of 15, do you also [53] require parental consent for many treatments that you would render to such a child?

A. Yes.

Q. What would your reasons be for requiring a parental consent in that instance?

A. I think the reasons for requiring the—my own feelings requiring parental consent is that, even if the child has come to me on his own for an examination, fine, I examine the child. I can explain to them what their problem is and then I explain to them what I feel ought to be done in terms of treatment.

My reason for involving a parent is frequently the child will not follow through on the treatment. Sometimes they do not exactly have a good understanding of what the problem is. I think it is based a great deal on immaturity. I think also the parent is still responsible for that child and that makes it rather important that they know what the child's condition is, why the child is being treated and what the child is receiving.

There are also some circumstances where the parent would rather know also if the child received such and such medication, for example; and so I think this is not strictly a judgment of the 14, 15-year-old. I think the parent has to be involved with that as well.

* * *

[54] Q. Are you familiar with the general pediatrics standard of care in the Akron area?

A. Yes, being involved in pediatrics here for a number of years; being in a group of five other physicians, being on the staff at Children's Hospital, being involved with the care of newborns at St. Thomas, City, General Medical Center, I am aware of what the standards are in the community. If I were not I could not keep my staff positions at these hospitals if I was not following the standard of care in the community.

Q. Is there a general, accepted rule of practice, to your knowledge, in the Akron area of pediatrics regarding notice and consent for medical treatment?

A. I think it is a general rule. My own part, as most of the pediatricians I deal with on a rather daily basis, which involves most of the pediatricians in this community, as a general rule of thumb, parents are notified of the patient's illness, of the child's treatment and generally before the child's treatment is instituted.

* * *

[77] [*Cross-Examination*] *By Mr. Landsman:*

Q. Doctor, I think you prefaced most of your testimony by saying you are opposed to all abortions; is that correct?

A. Yes, I did say that.

Q. I would take it from that statement you are opposed to all abortions in the case of minors as well as adults?

A. Yes.

Q. Doctor, you are opposed to abortions in cases of incest; is that correct?

A. Yes.

Q. You are opposed to abortions in cases of rape; is that correct?

A. Yes.

* * *

[80] Q. Are you involved in any special training in adolescent medicine, things of that sort, on a regular basis?

A. No, this is part of my training in pediatrics.

* * *

[86] Q. What is the percentage of your practice which is teenage girls?

A. That is a toughie. Five percent.

* * *

[87] Q. Now, Doctor, when you are explaining, for example, the risks of an appendectomy, to, let's say, an adolescent, do you explain all the possible complications that might occur?

A. No, I do not, and that is partly because, obviously, I would not be the one doing the appendectomy. I give them a general idea of what is going on, the possible complications of an infection that would involve them staying in the hospital longer; this type of thing.

It is the surgeon who will go into further explanation, whatever he feels.

Q. You do not give them every possible detail?

A. No.

Q. Now, if you were compelled to give them every possible detail, could that be detrimental to their health?

* * *

The Witness: Okay. I think, again, that depends on circumstances and what type of procedure [88] you are talking about. I think that has, too, at times, become an individual judgment. I do not think you can—

By Mr. Landsman:

Q. But it is individualized and there are times you would not want to give every complication?

A. Right, I think that is true.

* * *

Q. Now, in those cases if you thought that notification or inquiry of a parent would lead to further abuse, would you still notify the child's parent about treatment of the child?

A. I think if it is a situation where I felt informing a parent is going to lead to further abuse, you just do not let it drop there, then I think I would try and involve someone else in the situation.

Usually when we are in this type of situation you contact social service at Children's Hospital, so that there is protection [89] for the child.

Q. But—

A. In essence you are informing the parent then to what is going on, so—

Q. But, indirectly—

A. Once I think you feel that the child's welfare is being cared for, he is not going to get into further problems, then you let the parent know.

Q. So you protect the child first; is that correct?

A. Yes.

* * *

[91] Q. * * * If you got notice, unfortunate, that your daughter was pregnant, she was seeking an abortion, would your counsel to her include the positive aspects of the abortion option?

A. No, probably not directly.

Q. If you got notice that your daughter were pregnant and seeking an abortion, would you consent to that abortion if your consent were required?

A. No, I would not.

Q. If your daughter were to commence a court proceeding to seek judicial review of the abortion, instead of consent, would [92] you contest that proceeding?

A. Yes.

* * *

TRANSCRIPT EXCERPTS OF DR. "B"

VOLUME VII

[*Direct Examination by Mr. Dandrea:*]

[97] * * *

Q. And do you receive fees for the performance of abortions at that clinic?

A. Yes.

Q. And that is on a per patient basis?

A. Yes.

* * *

[98] Q. I am asking you now, Doctor, if you can, to go through with what you would say or do with a woman you have met the first time; now you are about to perform this abortion on her; would you just tell us, use the language just as though she is standing right in front of you, would you do that?

[99] A. Well, usually help her to counsellor, then I go introduce myself to the patient and ask do they have any question. If they have any question in that moment and I answer to them and then the patient sign the paper, after I introduce, after the question and then the check of the vital signs and then some patients they need medicine and I give her—I give the order to them. They don't think they want it we don't give them.

Then go to procedure.

Q. Is that medicine to calm their nerves if they are anxious; is that what you mean?

A. Yes.

Q. Where do you meet this patient; what room in the clinic?

A. The counsel room.

Q. And when you are meeting this patient, would she be with a number of other patients as well?

A. Yes.

Q. And would it be fair to say there would be no separation as to ages? There might be young women with older women and so on?

A. Yes.

Q. At that time are they in a gown or are they in their own clothing?

A. They are in their clothes.

Q. All right. Do you leave the room after asking them if there are any questions?

[100] A. Yes.

Q. They are still there when you leave the room; is that it?

A. Yes.

Q. Typically, do very many people ask questions?

A. Right, few people ask questions.

Q. A few?

A. Right.

Q. All right. In the time that you are in the room with that group of women, do you ever use the word "abortion"?

A. No.

Q. Do you ever use the word "pregnancy"?

A. In the counsellor room?

Q. Yes.

A. No.

Q. So it is just in general terms about, "Do you want to go through with it?" That is about it?

A. No, up on the counsellor room, when they come to the procedure room, at that time I can ask them personally. What I mean personal, I can talk to the patient one-to-one, instead of talking whole group together and I particular ask that particular patient say "Is that your decision?" And make sure that she make up her mind before I go ahead.

Q. After you leave the counselling room, where the women are in a group, do you go to the procedure room?

A. Yes—no, I stay for the vital sign, because they—

[101] Q. You check blood pressure?

A. Registered nurse check it.

Q. All right. And then what happens after the vital signs are checked?

A. Then they go change gown and ready for procedure.

* * *

A. Yeah, after they change their gown, then they sit in a room waiting for procedure.

Q. All right. And once again, in the waiting room they are all in a group?

A. Yes.

Q. All right. Is it in the procedure room that you talk to the women individually?

A. Yes.

Q. How long do you spend with a woman individually, in the procedure room?

A. I think around 15 to 20 minute.

Q. All right. What do you say to the patient in that period [102] of time?

A. As I just mentioned, I make sure that was their decision they want. And also I ask them do they have any major medical problem like diabetes, heart problem, seizure problem, something like that. After everything is okay they say, "Yes, this is what I want to be done," then I do it for them.

Q. Would it be correct then that at this point in the procedure room you assume they have already made the decision for an abortion and you do not see your role as counselling them at that point; is that correct?

A. Right.

Q. And at the conclusion of this 20 minutes then the woman assumes a position on a cot or a bed; is that correct?

A. I'm sorry, I didn't hear you.

Q. After this 20 minutes then, you go into the procedure, do you?

A. No, that 20 minute include the procedure—

Q. How much time do you spend talking to the woman?

A. —full procedure.

Before procedure?

Q. Yes.

A. Five minute, ten minute.

Q. Is that when the bimanual pelvic exam takes place?

A. No, that is after I talk to them, then I do the pelvic exam, then do the procedure.

[103] Q. Well, in this 20 minute period, could you

tell us then how much time is taken in talking and how much time is taken up in the actual procedure?

A. About 50-50, about ten minute and ten minute.

Q. All right. And then someone comes in, assists the woman to another recovery room or waiting room of some kind and patient two comes in; is that correct?

A. Yeah, after I do send patient to recovery room, then get ready for the second one.

Q. In your conversations with the patients, would you say that you understand them when they ask you questions?

A. Yes.

Q. All right. Does it appear to you that the patients understand you when you are talking to them?

A. Yes.

Q. Do they ask you to repeat your remarks—

A. Sometimes.

Q. —or comments?

A. Yes, sometimes.

Q. Have you ever received a comment from the patient that, "I don't understand you, Doctor"?

* * *

[104] ***The Witness:*** They don't understand me, the registered nurse stand by, they explain, but I think that happen very unusual, very seldom.

* * *

[110] Q. Would it be correct to say or not, in your experience have you performed an abortion on a woman under 15 even though her parents were not there, at least one parent was not there?

A. I cannot remember, but most generally the parent was there.

* * *

Q. Do you make any attempt to judge the maturity of the patient?

A. What do you mean "maturity"? Can you explain it to me? I don't understand what do you mean by "maturity"? Do you mean, the patient or the—

Q. I am speaking of the maturity of the patient, yes.

A. No.

* * *

TRANSCRIPT EXCERPTS OF FRANCINE LUCAS

VOLUME VII

[*Direct Examination by Mr. Dandrea:*]

[147] * * *

Q. How many counsellors are there at the clinic?

A. Three.

Q. And are they all part-time employees?

A. Yes, they are.

Q. Have you had any previous counselling work or employment?

A. As a respiratory therapist, I did some counselling.

Q. That was to, perhaps, explain to people what to do, maybe if they are having some problems with their breathing after they have operations or something; is that what that is?

A. Yes.

* * *

[148] Q. Now, in your own time there, how much time a week would you say that you spend in the birth control counselling, maybe in terms of hours?

A. Five hours per week, approximately.

Q. All right. So perhaps 15 to 25 hours then are in the counselling for women who might be undergoing an abortion?

A. Yes, also may include other duties, telephone counselling, as well.

* * *

[149] Q. Now, how much of your time might be involved in just answering the phone or perhaps receiving people, as they walk through the door?

A. Per day?

Q. Yes, let's do it that way.

A. One to two hours, approximately, in some instances.

* * *

[150] Q. And would it be fair to say that perhaps 85 percent of the people who come into your clinic undergo the group counselling and do not receive individual counselling?

A. Approximately, I'd estimate that. That's just a figure off the top of my head.

Q. And would it be fair to say that an individual probably would not receive the individual counselling unless she specifically asked for it?

A. In some circumstances we do speak to a patient individually, other than when she may request it.

Q. What might that circumstance be?

A. Ambivalence, possibly, about her decision, concerning the abortion procedure, or if she is a very young woman, in that circumstance, she may be individually counselled as well.

* * *

[152] Q. Could you tell us, perhaps what you typically convey or what information you might receive from a woman in a group counselling session?

A. Usually I would speak to the woman individually for a few moments, giving her ample time to understand that she may change her mind at any point, at anytime she's at the clinic, before the abortion procedure is begun.

I then take her into the group counselling room. She's given a care sheet of instructions and time to read that over prior to the counselling session itself.

She's then given information about the abortion procedure itself, what she may expect to experience during and after the procedure. I tell her how much time she will be spending in [153] each area of the clinic, the laboratory, the procedure room, the recovery room. I explain which personnel members she will have contact with.

I give her information about what she can expect, possibly to experience for the two weeks following the abortion procedure, the aftercare period of time, as we call it.

I may give her information about follow-up examination, when she should have it following the procedure. She's given birth control information at that time also.

She's explained hazards, possible complications that may occur during the procedure. She's given time to read over the consent form and a package that lists the risks and complications that may be involved; and a signature's required on both of those.

She then is in the group session. The patients are then introduced to the nurse and the doctor and they're given ample time to discuss anything they may choose to discuss with those individuals. Then anything, any questions that may arise can be handled individually, when it is going on, any comments the woman may have. It may vary from one session to another, of course.

Q. Would you say there is one or more questions which are more frequently asked of you than other questions, by these women?

A. Yes.

Q. Can you tell us what that question or questions might be?

[154] A. How much pain may be involved is frequently asked. And how much bleeding they can expect to experience afterwards, probably are the most frequently asked.

Q. A moment ago you generically said, "We explain the procedures;" can you use the words now you would use on the woman and tell her exactly what is going to happen to her?

A. Initially the doctor will perform a pelvic exam. I explain to the patient the gynecological table, especially in a circumstance if she has never previously been examined in this manner. I explain to her the position she'll be lying in on the table, exactly what the doctor will do during the procedure—during the examination, rather.

I then show her the vaginal speculum, the instrument that is inserted, initially. I show her illustrations of pelvic exam and illustrations and pelvic organs, which show these instruments in place.

Then I explain to her how the procedure progresses from that point, step-by-step, the antiseptic that is used to clean out the area, vagina and cervix. I explain to her which instruments are specifically used here, tenaculum, which is attached to the cervix at this point to stabilize it.

The patient is then given a local anesthetic, which is injected into the cervix. The doctor begins to dilate the cervix or open it up after that point. This is achieved with a set of instruments designed for that purpose, dilators.

[155] I explain to her how that progresses, starting with the smallest dilator, gradually, step-by-step, opening the cervix, in small degrees, each time by the dilators gradually increasing in size.

Then I show her a suction cannula, which is the instrument that is inserted directly into the uterus. I explain to her what she may be experiencing here, what sensations may be at this point, indicating to her, all along the procedure, how long the procedure may take also.

Let's see, the doctor then uses an instrument called a curette, after that point, to make certain he has cleaned the contents of the uterus out, removes that.

That completes the procedure; is that sufficient?

* * *

[159] Q. Have you graduated from college?

A. No.

Q. Did you attend college?

A. Yes.

Q. Bowling Green?

A. Yes.

Q. Two years?

* * *

[160] Q. Now, you mentioned earlier, I think, respiratory therapy; coming now to your position at the clinic, can you tell us what training you received at the clinic for your position as counsellor?

A. I was instructed by a nurse, who hired me at the clinic, and a counsellor that was previously or presently, at that time, employed there.

Q. Did this training take place at the same time, that is to say, both of them trained you or instructed you at the same time?

A. No.

Q. All right. How much time did you spend with the nurse and what was done in that time?

A. Oh, I spent approximately four hours discussing with the nurse exactly what I would be doing in a counselling capacity at the clinic. Four hours at various times, not at one interval.

* * *

[161] Q. How much time did you spend with the counsellor in this training?

A. About the same length of time.

Q. Was the training with the counsellor something like on-the-job training; that is, were you standing by while she was counselling other people, prospective patients?

A. Initially the other counsellor just spoke to me privately, individually, referring to pamphlets and books and illustrations. Then I did observe her in a counselling session as well.

Q. Was there anytime that you spent with the doctor at the clinic?

A. Yes.

Q. Specifically, toward counselling information or training by him toward you?

A. Yes.

Q. How much time?

A. I would estimate that to be about an hour.

* * *

[166] Q. Is it anyone's responsibility at the clinic to judge the maturity of a woman under the age of 15, who intends to go through an abortion procedure at your clinic?

A. I don't know.

* * *

[168] Q. * * * Of those women who undergo abortions at your clinic, would it be accurate to say most of them had visited your clinic only once, that day of the procedure, wherein they received a pregnancy test, determined to be pregnant and had the abortion?

A. Yes.

* * *

[169] Q. All right. Calling your attention to number three; routinely is it conveyed to women that the unborn child is a human life from the moment of conception?

A. No.

Q. Is it conveyed to her the anatomical, physiological characteristics of the particular unborn child, that which—

A. No.

Q. Is it conveyed to her other such characteristics as mobility, tactile sensitivity, including pain perception or response, brain or heart function?

A. No.

Q. Do you feel any of those things I mentioned in subsection 3 are relevant?

A. No, I don't.

* * *

[170] Q. With respect to your answer number one, two and three, do they still stand then with respect to my question of relevancy?

A. Yes, they do.

Q. Told her number four, capable of surviving outside the womb if more than 22 weeks elapsed from the time of conception?

A. No.

Q. Do you feel that is relevant?

A. Our clinic doesn't see patients that far along in their pregnancy, so I don't feel it is relevant.

* * *

Q. Number five, is it typically conveyed to her that abortion is a major surgical procedure? Well, do you convey it?

A. No.

Q. Do you think it relevant that that information be conveyed to her?

A. That it is a major procedure? No.

* * *

[171] Q. And do you make mention to her there are numerous public and private agencies to assist her during her pregnancy, even to the point of helping her to full term and even to the point of perhaps providing an adoption?

A. Yes.

Q. Is that told to her?

A. Routinely, no.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[174] Q. What do you understand your role of counselling to be then with a minor?

A. To inform her of what is involved in the abortion procedure, the possible complications that may occur, how to care for herself, so that she progresses and recovers with no problems.

Q. That is all information giving; is it then a fair statement to say when you counsel a minor you understand your role to be information giving only?

A. Yes.

* * *

Q. * * * My question, again is, does it happen at your clinic that a minor under the age of 18 gets only group counselling?

A. No.

Q. In other words, she always gets individual counselling?

A. No, she may—

Q. Explain it.

A. She may get exclusively individual counselling or she may get group counselling and if she's 15 or under, we also speak to her individually.

* * *

[175] Q. And a 17-year-old may only get group counselling; is that correct?

A. Yes.

Q. Does it happen at your clinic that a 16 or 17-year-old, pregnant girl would receive only group counselling when her parents were not on the premises?

A. Yes.

* * *

Q. Have you ever affirmatively contacted a parent with the permission of the minor?

A. No.

* * *

[180] Q. Do minors get that pre-medication on occasion?

A. Yes.

Q. Who gives it to them?

A. The nurse gives it to them.

Q. Do you ever administer that?

A. No.

* * *

Q. Sure. Upon whose authority does the nurse dispense [181] tranquillizers or the pre-medication to minors?

A. The patient's, whose authority, the patient consents herself.

Q. Does the doctor give the nurse permission or instructions to dispense it in any given particular instance?

A. Not to my knowledge; it is a routine procedure.

Q. So, to your knowledge, it would be a decision between the nurse and the minor patient?

A. Yes.

* * *

[184] Q. Miss Lucas, you were asked whether you have, yourself, in [185] your role as counsellor, referred a minor to a physician, other than the physician at WomenCare; I want to ask you whether you have referred a minor patient at WomenCare elsewhere for counselling?

A. Yes, I have.

Q. And under what circumstances have you?

A. Ambivalence about the abortion procedure, definitely if the patient is unsure whether she wants to go through with the procedure.

Q. Then you refer her elsewhere for counselling, before making the decision; is that correct?

A. Yes.

Q. And can you tell us where you would refer her for that counselling; do you make specific referrals, specific suggestions of places to go?

A. No, depending upon where she lives. I try to refer her to somewhere in her area.

Q. Okay. So if she lives in the Akron area is there a particular place you might suggest she should go to get that counselling?

A. Not a particular place, but I can give her a listing and let her select.

Q. Okay. What would that entail, include?

A. Pardon me?

Q. What would that listing include?

[186] A. Shall I name them?

Q. Yes.

A. Portage Path, which is a psychological counselling facility; Western Reserve Rehabilitation, possibly, or various private psychologists or counsellors that she may see.

Q. Miss Lucas, your answer, in response to a question by Mr. Umbaugh, I believe, that you felt that the purpose of your counselling at WomenCare was information giving; is that correct?

A. Yes.

Q. Does that mean that the format of the counselling that you provide to the patients would be in the nature of lecture?

A. In the group session initially it is, but I also provide supportive counselling to the patient.

* * *

[*Cross-Examination by Ms. Roberts:*]

[187] Q. Okay. Let's go back again to the counselling prior to the procedure.

Now, you mentioned that there is initially individual counselling; is that correct?

A. I have a period of time to speak to each patient individually, yes.

Q. Okay. During that period of time, that you speak to each patient individually, are you, during that time, only giving information to her, or are you doing something else?

A. I may be asking her how she feels about the abortion procedure, whether she wants to have an abortion. So I may be questioning her.

Q. And in the counselling with the group, does that process, in addition to providing information, does that include any effort to elicit questions or discussion or responses from the patients who are in the group?

A. Yes.

Q. Is that a large part of that counselling session, a significant part of the session?

A. Definitely is significant. The majority of the time is spent, initially, giving patients information. After that time I engage in a discussion, cross-discussion if you will, with the patient herself.

* * *

TRANSCRIPT EXCERPTS OF DR. MYRE SIM

VOLUME VIII

[*Direct Examination by Mr. Bickett:*]

[24] * * *

Q. Doctor, are you aware of any studies with any conclusion from a psychological viewpoint that abortion is safer than carrying the pregnancy to term?

A. Yes.

Q. What would those studies be, Doctor?

A. Well, I did refer to the flaws in these studies in that they are usually on relatively small samples. In fact, such studies would have declared thalidomide to be a safe drug and actually thalidomide—

* * *

Q. Doctor, these studies, which you are aware of, that had the conclusion that from a psychological viewpoint abortion is [25] safer than childbirth, was there a problem with these studies?

A. Yes.

Q. And what was that problem?

A. The problem was that the numbers that—assuming the condition is not a common condition and, as I said before, assuming it is of the same incident, no more, no less, and the post partum psychosis that they would need to have studies of not less than about 10,000 patients, aside to do a proper control study. I said that had not been done or anything approaching it.

The largest study to date was the one done from Aberdeen where they took 180 on one side and 120 on the other and the surprising thing would be if they found anything in that study and they did not. They said the

results of that study was abortion was no worse than pregnancy. It was not safer, it was no worse. It was a meaningless study in terms of numbers.

Q. Doctor, referring you to what has been marked as a copy of Plaintiffs' Exhibit 44 and at this time, Doctor, I would ask you to turn to Page 3. At the bottom of the page is a Section 1870.05 titled, "Notice and Consent"; do you see that, Doctor?

A. Yes.

Q. Are you familiar with that Section?

A. I have read the Ordinance and I recall reading this Section.

Q. Referring you, specifically, to Sub-division A; are you familiar with that sub-section, Doctor?

[26] A. Yes.

Q. What impact, if any, would that have on an unmarried, pregnant woman under the age of 18 years?

A. I cannot see anything offensive about this.

Not only have I had no information, I know nothing in the literature to support it, so I would say that is quite inoffensive.

Q. Doctor, would there be any specific dangers to a patient whose parents were informed?

A. You are asking me to be a prophet; I find that rather difficult, but I can say that I have not met, in my very lengthy experience, any dangers arising from it, and I know of nothing of that nature that has been reported by other workers. So if there are any, it has been kept a secret.

Q. Doctor, in your experience and based on your studies, how would a minor, that would be under the

sub-division of A there, tend to react to the knowledge that her parents would have to be notified?

A. Well, there is no general rule about it, some are very concerned and do not want the parent to be informed, and others do not object, so you really cannot generalize. But in the instances we have had, where young girls have been in the situation—

* * *

[27] *The Witness:* In the instances which we have had where the young girl was rather concerned about her parents knowing, either myself or my social worker was able, not only to put it that it was going to be helpful to her, but we always found the parents rallied round and were very supportive indeed.

We did not meet a situation where a parent adopted a hostile or threatening or castigating attitude. They realized the daughter was in trouble and as parents it was their job to help her; and as I say we got full cooperation.

Q. Doctor, in the cases dealing with parents and the minors in the problem pregnancy situation, have you had any experience with reactions of the parents to finding out about their daughter's pregnancy?

A. Initially some of them are very shocked and concerned and distressed. Some parents, in fact, want the child to have an abortion and they come with their child for that purpose. Others do not want their child to have an abortion and say, "Can she go through with the pregnancy and we will help her?" You get a variety of reactions, some are anxious for her to have an abortion and others are anxious to go to term.

[28] It is supportive of the role according to their lives. If they feel abortion is the answer, they will

support her on that; but if they feel abortion is not the answer, they will support her in that. Generally it is a supportive, at least in their light, a supportive action.

* * *

Q. Are there any psychological dangers which this Section would create to a pregnant woman under the age of 15 years?

A. I would say to the contrary; I think a girl of 15 needs her parents' support and this is one means of getting it. I think [29] it is helpful.

I would say that not having parental support and to be left to the charity, if you like, of strangers is not the best situation for a girl of 15. I would put my confidence in parental support rather than the professional support.

* * *

Q. Doctor, do you have an opinion, first of all, as to whether or not, in general, a female patient of any age runs a risk of psychological dangers from having explained to her all facts and details about the abortion decision and process?

A. I have not had any such experience, and I know of no such reports. No one has collected even one case where, as far as my reading of the literature, a girl, young girl, who has been told this has suffered a psychiatric illness requiring psychiatric treatment. There is nothing I know of in the literature to support this.

Q. Doctor, referring you, specifically to Sub-division 3, the [30] first statement, "That the unborn child is a human life from the moment of conception;" first of all, Doctor, to your knowledge, is that statement true?

A. That is biologically true.

* * *

Q. Doctor, would, giving that statement that the unborn child is a human life from the moment of conception, create any psychological dangers for patients who would receive it?

A. I cannot see it and I do not know of it. It is true, factual, to say otherwise would be untrue and dishonest.

* * *

[31] A. Usually the pregnant woman or girl is curious about the stage of her pregnancy and she knows that there is a child developing within her. I think if she is going to have surgical intervention she ought to know and probably will want to know the degree of development, because I have had an instance or two instances of women who have had an abortion, but they were incomplete and later, perhaps a week or two later, they found, in the discharge, the remnants of an identifiable human anatomy, like a little bit of a foot or so on, and were horrified to think that their abortion had reached such a stage when it was done.

I know that is much more traumatic, these are cases which have come to my notice and certainly quite traumatic and quite a shock for them to know it had been so advanced, and this was a thing which looked human.

So I will say, in my experience, there is more risk in not telling them, in case they discover later what it really is, than telling them initially.

I think it is standard medical practice in any operation to describe exactly what is going on. In fact, doctors are required, almost by law, to do so.

Q. Okay. Doctor, now, referring you down to Subdivision 5, the statement, "That abortion is a major surgical procedure;" is that statement true?

A. Oh, yes.

* * *

[32] Q. Doctor, referring you to the next part of Sub-division 5, the information that abortion, "Can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies;" would the giving of that information create any psychological danger to the patient who receives it?

A. I do not think it would create any psychological dangers in that they will suffer from an illness which will require [33] treatment or may not even be susceptible to treatment. This is very much in the mold of the cautions which are given with most treatments, in fact, not very different to what you may find on a packet of cigarettes, or even a household remedy in a drugstore which you buy over the counter.

* * *

Q. Doctor, referring you now to the next statement in Sub-division B5, the statement, "That abortion may leave essentially unaffected or may worsen any existing psychological problems she may have;" first of all, Doctor, is that true?

A. Yes, "may", yes, but not "will".

Q. Well, on what do you base your opinion that it is true, Doctor?

A. Well, we have the information in our post-abortive psychosis, in fact, that information we gave to the Lane Committee and included in their report and said the caution should be exercised [34] in recommending an abortion to someone with a previous history of mental illness, because there is evidence, quite strong evidence, they are much greater risk to aggravation.

Q. Doctor, referring you to the next statement that that abortion can result in severe emotional disturbances; is that true, Doctor?

A. It can result in severe mental illness, yes.

Q. Can it result in anything short of severe mental illness?

A. Yes, when you have severe mental illness it is really the tip of an iceberg, and underneath you have moderate degrees and mild degrees. In fact, this type of information is coming through from other sources.

* * *

Q. Are you aware of any studies or literature dealing with emotional disturbances after abortion?

A. Well, at the last Canada Psychiatric Association, just almost 12 months ago, there was a paper from Vancouver from a psychiatrist, a Dr. Kent, who reported on 30 patients he had in psychotherapy where the psychiatric problems, and these were only declared, during psychotherapy and not immediately after that abortion, but in psychotherapy their problems were very closely linked with their abortion procedures and their reaction to abortion.

* * *

[35] Q. Doctor, would the giving of information concerning adoption and public and private agencies to assist an individual during pregnancy and after the birth of a child; giving that information in the decision-making process, would that create any dangers for the individual?

A. Well, if a decision-making process is based on options, it [36] must be given and should be given and will not create any danger.

* * *

Q. Doctor, now referring you to the area we have just talked about: Fetal characteristics, is the statement an unborn child a human life from the moment of conception; that statement together with abortion is a major surgical procedure, it can result in complications, can result in severe emotional disturbances; your answers have been that there would be no serious damage from those statements; would that answer change if this information were being given to someone who had already made up their mind to have an abortion?

A. Well, making up one's mind is a very complex situation. For example, we find that unwanted pregnancies very rarely persist after the three months of pregnancy, then it becomes a very much wanted pregnancy and a very much wanted child; that is our experience; I think the experience of most people.

So to say a person has made up their mind, I think, a young girl, particularly, who finds herself pregnant with a social problem involved is not in a position really to make up their [37] mind without knowing what the alternatives are and knowing there is in the society and in the family a lot of benevolence towards her and support which she could have.

So when you say "Make up their mind," I think circumstances are not conducive to a firm decision unless all these other points are put to them.

Q. Doctor, the information, once again, in one through seven, which we have been discussing, would any of that information cause guilt feelings within the individual?

A. Yes, it could.

Q. And could you refer to what information that would be?

A. Well, I think if a person is contemplating an abortion and they know that it is not just a collection of undifferentiated cells with no human connotation whatsoever and they are told it is not that and it is human and they say 12 weeks pregnant and, in fact, the fetus is visibly identifiable as human, this could make them feel very guilty about it; but very rarely.

I will not give you my explanation unless you ask for it.

Q. Is the guilt that would be created from such statements good or bad?

A. I do not see guilt as an evil thing.

* * *

[38] *By Mr. Bickett:*

Q. What impact, Doctor, would those guilt feelings, that are generated, which you have just described, have on the individual who is feeling that guilt?

A. I think this is almost out of the realm of psychiatry. This is almost in the realm of social behavior. I do not think it would be any more severe.

* * *

Q. Yes, Doctor?

A. I say it would be rather similar to someone who feels guilty either having attempted to steal or having stolen. They would be very distressed about it, but we do not necessarily—do not have them coming to us as a psychiatric calamity. It is a learning experience, in fact, and many people would say there is not enough guilt feelings associated with conduct and society.

It is not the policeman, who is watching the individual, that stops crime; it is the person's sense of guilt that what they do is wrong is the biggest deterrent to crime.

Q. Doctor, will the guilt feelings, or can the guilt feelings have any beneficial effect on the individual herself?

* * *

[39] Q. Yes, Doctor?

A. I am sorry, I lost my thought.

I do not think it is in the realm of psychiatry except that, and I think in fairness to the other side, excessive guilt feelings are found in mental illness too. So you can get an excessive reaction to guilt, which is pathological and needs treatment and can be very serious; but all I can say, I have not found that and not heard of it occurring under these circumstances. That it cannot occur, I cannot say.

* * *

[40] Q. Doctor, what is the likely reaction of an individual, such as a minor under the age of 15, what is the reaction of that [41] person and what would they do if they were refused an abortion?

A. There is no evidence of anything catastrophic. For example, suicide is extremely rare. In fact, pregnant girls or mature women have a lower incidence of suicide than women of similar age in the community. In other words, in a way pregnancy is an insurance against suicide, if you like to put it that way; because their incidence is lower.

So, from the extreme reaction of suicide it is less. In terms of mental illness it is also less.

* * *

[42] Q. Would the 24 hour time period, as presented in that Section, create a risk of psychological problems of psychological danger to the patient?

A. I cannot see that at all. I have not met it and do not know of anyone else who has met it.

* * *

[43] Q. Doctor, a wait of 24 or even 72 hours, in obtaining an abortion, would that create a physical danger—

A. No.

Q. —to the patient?

A. I would say, generally, no. One could envision a certain situation where an emergency arises, and even an hour can be a danger; but if there is no medical or surgical problem, no.

* * *

[45] Q. Is the minor more susceptible to problems compared to adults?

A. No, there is no evidence of that. In fact, less probably affected than adults.

* * *

[48] Q. Who should be the one, in your opinion, that explains the aspects as set out in 1870.06?

A. Well, it is general medical practice for the doctor to do that. He knows what he is doing. He knows exactly what the position is. He has the experience. He can answer the questions that may follow.

It is not just giving them this information, you have to be prepared to answer some questions. I do not think anybody, other than the doctor himself, can do that. This is very technical and anybody else would be presumptuous.

* * *

[*Cross-Examination by Mr. Destro:*]

[52] Q. All right. Thank you.

With regard to the psychological maturity of an adolescent, would there be any specific problems, to your knowledge and in your experience, in the reaction of an adolescent to a pregnancy or abortion situation?

A. The thing that surprises one is how relatively unaffected they are sometimes, compared to adults. They seem to take these experiences surprisingly well.

Now, one may argue this, maybe an initial stage and later on they may not, but in one's subsequent study of patients who may have had abortions early on, they do not seem to be traumatized. They are surprisingly unaffected.

* * *

[*Cross-Examination by Mr. Landsman:*]

[54] Q. Doctor, I noticed on your resume that one of the articles you have written concerned the use of oxypertine in combination with imipramine? Is that right?

A. That is quite right.

* * *

Q. * * * With reference to that one, those drugs are psychoactive drugs, are they not, sir?

A. Yes.

Q. The paper that you wrote on that report describes an experiment on psychotic patients, does it not?

A. Yes, depressive patients.

* * *

[55] Q. * * * Now, did you ask them, each of the psychotics in the hospital, to consent to the procedure?

A. Oh, yes.

Q. You did?

A. It is mandatory.

* * *

[56] Q. * * * Who obtained the consent?

A. I did.

Q. Were you connected with the experiment?

A. Yes.

* * *

[57] Q. Was consent obtained for this experimentation from anyone other than these patients in the hospital?

A. No, they are all responsible citizens who are capable of giving valid consent and information which would –

Q. Were guardians or relatives, outside the hospital, even [58] notified of the experimentation?

A. Oh, yes.

Q. They were?

A. Oh, yes.

Q. But their consent was not gathered?

A. No, not necessary, no. Not according to our laws, no.

* * *

Q. Was each patient in this experiment told that the two drugs used could have possible side effects, including convulsion, cardiac arrhythmia, seizures and a long list of other problems?

A. With imipramine that has been defined and these are listed, yes.

Q. Were they all told, each patient told of those risks?

A. Yes.

[59] Q. Each patient was told of those; is that right?

A. They were all listed.

Q. They were listed in writing, sir?

A. Yes.

Q. They were given to a patient?

A. Yes.

* * *

Q. Was each patient told, Doctor, the amount of the drug, the effective dosage of the drug? Doctor, that has not been actually defined.

A. Oxypertine we are not sure how much they should have.

Q. Had the patients been told that?

A. Yes.

Q. Was it true, Doctor, 56 percent of the subjects suffered side effects from the drugs?

A. Yes.

Q. Is it also true, Doctor, their side effects lasted more [60] than one week?

* * *

A. Yes.

* * *

[79] Q. All right. In your experience, as a psychiatrist, as a medical professional, are parents always supportive of their minor children?

A. In the circumstances of a pregnancy, yes.

Q. All the time, every case?

A. In our experience.

Q. That means in the 56 cases you have seen—

A. Or more, because it did not all come from abortion.

Q. But in every one of those cases the parents were supportive?

A. We found that there was sometimes initial reaction and being upset and felt let down, but, as I said in my

testimony, a very short time even when it was negative initially, that was very soon put right.

Q. So in every case the parents were supportive?

A. We were able to enlist the support of the parents.

Q. Now, Doctor, have you ever dealt with any cases of child abuse by parents of their children?

A. Yes.

Q. In those cases were the parents supportive of their children?

A. Frequently they were very fond of their children.

* * *

[80] Q. Now, in cases of child abuse, sir—

A. Yes.

Q. —I asked you, have the parents in those contexts been supportive of their children?

A. Well, if they have beaten the children then, obviously, they are not supportive in all respects.

Q. Have you ever dealt with any cases of incest?

A. Yes.

Q. Now, in those cases have the parents been supportive of their children?

A. No.

* * *

[82] Q. Now, that would be in all cases? There would never be a case then, Doctor, where patients would say, "I don't want to hear more, you are causing anxiety. I don't need to know more, please don't tell me." There were never—

A. I could not say never.

Q. You could not say no?

A. No.

Q. There might be some cases?

A. It is always possible.

Q. In those cases should the physician persevere, should he press forward with his statement?

A. I do not think one can give a general answer to it. He has got to use his clinical judgment and in most instances he should be able to overcome this resistance. It is just possible for [83] some strange reason this person is so unstable—

Q. Now, this is not most cases, Doctor, I am talking all cases. Are there cases where he should not persevere?

A. I have no experience with a case where that is a risk.

Q. That is not my question. If that kind of case arose, should he persevere?

A. To the nth degree, you mean?

Q. Should he carry on with the description of the fetus or all the risks of the procedure, or whatever?

A. Well, if one is faced with such an unusual situation—

* * *

I say if one is faced with such an unusual reaction I would be severely concerned about the stability of the individual and what is causing this extreme reaction and the whole attitude to the abortion procedure. It would widen the scope of my problem, I would have to think I am dealing with a sick girl, who is already sick, who is asking for an abortion. Her sickness in itself may require—

The Court: Well, the answer to [84] the inquiry is, should you continue carrying on instruction and describing the provisions outlined in the Ordinance?

The Witness: No, if I decided she was sick.

The Court: In other words, you are saying there may be a case you should not; is that correct?

The Witness: Oh, yes, there could be instances you should not.

* * *

[88] Q. All right. In giving informed consent information, Doctor, is it important to discuss all the options available to the woman?

A. All reasonable options.

Q. Now, do you see, in this material, 1870.06B, any discussion of the potential advantages of abortion?

A. I do not know the advantages, perhaps you can tell me what is omitted.

* * *

The Witness: I do not know any advantages.

* * *

TRANSCRIPT EXCERPTS OF DR. JOHN C. WILKE

VOLUME IX

[*Cross-Examination by Mr. Landsman:*]

[66] * * *

Q. Doctor, is it your opinion that all women who seek an abortion should be shown the photographs of the fetus and have a description in detail of fetal characteristics, sir?

A. Yes.

Q. What if a patient says that she does not wish to see the photographs?

Would you persevere anyway, sir?

A. I would tell her that she would see them sometime in her life and I believe that it is in her interest that she look at them prior to her having the procedure for they might influence her judgment at this time.

Q. If they request that they not be shown to her, sir, would you persist?

A. I certainly would not.

Q. If she requests that you not go into any description of the fetus, would you still describe the fetus to her?

A. In her best interest I will try to have her accept that information but if she refuses, then as a counselor I will not persist.

Q. Can the doctor's use of words like "baby" or "unborn child" influence or affect a patient trying to decide on whether to have an abortion or not?

[67] A. This is probably true. It swings both ways. If one uses a term that is commonly associated with "baby" or "live child", that might well have an influence.

If you use a term that is commonly accepted as nonhuman, such as "embryo" or "fetus", then that also has an effect.

Q. Doctor, is the following a correct quotation from your book, "Handbook on Abortion" at page 198?

"'Product of conception, fetal tissue, globe of protoplasm, fetal placental unit' and other high sounding phrases are all direct denials of the humanity of the growing child. Make up your mind. If you are convinced that this is a human life call it such. Then consistently speak of he or she, not it, and speak of an unborn, preborn or developing child or baby. It is easier to approve killing of a fetus, much more so than the killing of an unborn baby."

Doctor, is that statement from your book?

A. That is correct, a correct statement.

* * *

TRANSCRIPT EXCERPTS OF DR. RICHARD T. F. SCHMIDT

VOLUME X

[*Direct Examination by Mr. Bickett:*]

[13] * * *

Q. Doctor, are you aware of any policy of the American College of Obstetricians and Gynecologists, or of the hospital in which you practice, concerning surgical procedures on individuals under the age of 18 years?

A. Yes. It is standard practice and habit throughout my medical career to have consent from parents of a minor child for any surgical procedure.

Q. Are there any exceptions to this, Doctor?

A. In a life-threatening emergency, but even then the permission is obtained at the earliest possible time.

* * *

Q. Doctor, based on your studies and reading of literature and your own experience, what is your opinion concerning [14] the capability of an individual under the age of 15 to give an informed consent in that situation?

A. Well, I think it is very limited. In my medical practice I would never attempt to undertake a surgical procedure on a minor child without having explained it to the parents. The younger the minor child, the more this is required.

Obviously if a child is responsible, I would include the child and do. This is pretty standard practice, but not only is an abortion not any different kind of situation, and in many ways I think it requires more attention to be sure of understanding and mature judgment, and this is why I believe that involvement of the parents is perfectly appropriate and necessary.

* * *

[*Cross-Examination by Mr. Landsman:*]

[38] Q. Doctor, you don't perform any abortions, do you?

A. Elective abortions, no.

Q. The hospital for which you work does not perform abortions, does it?

A. That is true.

Q. In fact, the hospital for which you work has a policy prohibiting abortions; is that correct?

A. That is true.

* * *

Q. You are prohibited from performing abortions by a sectarian rule?

A. We are prohibited by a rule. If you characterize it [39] as sectarian, you may do so.

Q. Do you not receive instructions under the guidance and religious direction from the Catholic Health Association?

A. There is such a directive.

Q. And you follow that directive on abortions?

A. The hospital rule follows that directive, correct.

Q. Doctor, do you personally oppose all abortions?

A. I do not oppose anybody doing—well, I do not oppose—everybody doing an abortion under any circumstances. It is not a general opposition. I believe that abortion is inappropriate medically and ethically, and I do not do them, but I just want to make it clear, and I believe my general background indicates that I believe in the pluralistic society—

* * *

[84] Q. Let me ask this again:

If that young woman told you that she did not want to hear any more material of the type contained in (b)(3) before you got into the anatomical description, would you tell her anyway?

A. If I had no assurance that she understood that information to begin with, I would tell her in exactly the same sense that someone who is to undergo any other surgical procedure said, "Look, don't tell me that."

I might limit the amount I told her, but I would still feel obligated to be sure she understood.

If she said to me, "You don't have to tell me, I understand these risks," then that would have fulfilled my obligation.

* * *

[85] Q. Now, that patient tells you that she understands that it is a baby and growing in her, and she doesn't want to hear that anatomical description, and it will cause her pain; would you proceed to do it anyway?

A. No. If she understands, then I have fulfilled my mission in being assured that she has that information.

* * *

TRANSCRIPT EXCERPTS OF DR. JASPER WILLIAMS

VOLUME X

[*Cross-Examination by Mr. Destro:*]

[142] * * *

Q. Do you have an estimate from your experience of how long it would generally take to resolve such a kid's perception of how her parents would act or resolve her situation with the parents after her actions, from your experience?

* * *

[143] A. * * * Some kids at 14 are more mature than their parents, and you have more trouble talking to the parents than the patient, so I can't put on a time limit, but I would say 15 minutes to an hour or an hour and a half, and sometimes it goes two hours.

* * *

TRANSCRIPT EXCERPTS OF DR. MILDRED SHELLY

VOLUME X

[*Direct Examination by Mr. Dandrea:*]

[186] * * *

Q. In your practice or experience could you say typically how long a period of time you might spend counseling one contemplating an abortion?

A. Personally I would prefer to spend at least two to six sessions with the person.

Q. How long a session?

A. At least an hour.

* * *

[187] Q. What area might you cover in the counseling of a woman contemplating abortion?

A. Primarily I would begin by putting out the extreme importance of her as a person to me. I would try to give her some concept of what she tells me of how I see the stress which she is having, and then I would ask her if I were on the right path with her; in other words, have we established a rapport.

Beyond that I would ask her what she might have and how she might see her own survival, as well as that of the child within her.

Q. In your discussions with her, would, even in a general fashion, would her own obstetrician come up in this conversation?

A. That may be the case, yes.

Q. Would you ever suggest that she have counseling with him and discussion, anything with him?

A. Very definitely.

* * *

[192] Q. In the context now of counseling anybody now, whether an adult or minor woman, could you give us what in your opinion is the significance here of informed consent and some of its ramifications?

A. I think in counseling anyone, particularly now, there is a very great need for informed consent, because I think very often we as physicians—and I am speaking for myself, if I may—I think that we are not always perceptive enough to know when the patient herself—I know very often myself in talking to patients have them give me some kind of feedback, so I know we are tuned in on the same channel, as it were, because when people are under stress, there is a tendency to distort what they hear, and if you don't get immediate feedback and reinforcement of the understanding, you may find yourself in difficulty the next time that [193] you talk to the person.

Informed consent too I think is the acknowledgment with whatever intelligence the person has with whom you are talking in trying to explain a procedure to them, and the alternative and the results.

Q. Well then, was there not restrictions tied to abortion in any area on how much ought to be told or communicated? When does, in general terms, when does this informed consent become truly informed?

A. When you get some feedback that they understand the nature of the procedure in their own terms and their own language, and if you can't explain it to them, you better get somebody who can in terms of their language, or if they might be deaf or something, and you have to have understanding from them about why they are there for the procedure and what constitutes the procedure and what might happen.

Q. What might the results be if perhaps a given area of this discussion is omitted, whether advertently or inadvertently?

A. If the natural reality of the issue of abortion is not understood, depending upon the level of the person, it quite often is a shock to them, especially for early adolescence, because abortion very often [194] directs itself to relief of the stress of the mother, and at some point in time, as the youngster grows older, they become aware of the fact that this was indeed another person.

* * *

[195] Q. Could you state, Dr. Shelly, in the role here of counseling or treatment here with, let's say an unmarried minor contemplating an abortion, does the counseling or perhaps the language thereof in any [196] way affect that person's maturity?

A. There is ultimate maturity, and I wouldn't say, but there is maturity as they are going through adolescence, and I think it would affect it for this reason:

They need parents. They need parents to be children, and to survive to adolescence, and they need them, not necessarily for the support they are going to give them, but because they need them at the taking off place into their own adulthood to separate themselves and begin to adopt their own adult roles and find their own sexual identity, and all of these things, positive or negative, these parents represent roles to them.

* * *

PLAINTIFFS' EXHIBIT 10

AKRON CENTER FOR REPRODUCTIVE HEALTH
CONSENT TO ABORTION FORM

I, _____,
age _____, hereby give my consent to, and request and authorize Dr. _____
or whomever he/she may designate, to perform upon me, an ABORTION, and if any unforeseen condition arises in the course of the abortional procedure that in his judgment calls for procedures different from or in addition to those now contemplated, including but not limited to, the administration of anesthesia and the administration of Rhogam. I further consent to and request and authorize said doctor and his assistants to do whatever else he or they deem advisable in the exercise of his or their best medical judgment.

As in any surgical procedure, bleeding and infection are potential complications of abortion procedures. These complications could cause prolonged illness, the need for blood transfusions, and permanent inconvenience and disability. During the course of the operation, it is possible that the wall of the uterus will be perforated or punctured. This could cause pelvic bleeding and infection, and even bleeding and infection in the abdomen. Problems with blood clots in the legs, pelvis, and lungs also rarely occur after abortion procedures. There is also a very remote chance that one or more nerves going to the legs will be injured during the operation.

Some of the complications of this operation can require further major surgery; some could potentially result in sterility or the permanent inability to become pregnant again; and very rarely, some of the compli-

cations can even be fatal. There are other potential complications from the abortion operation in addition to the ones that have been mentioned. However, it is not possible to advise you of every imaginable complication. The complications referred to are very unlikely. The purpose of this consent form is merely to insure that your decision to have an abortion is not made in ignorance of the risks of this kind of operation.

I further consent to the disposal by my attending physician or his assistants of any tissues or parts which may be removed during the course of the abortional procedure.

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained as a result of submitting to an abortional procedure.

Date _____

_____

Signature of Patient/Consentor

_____

Witness (Counselor)

PLAINTIFFS' EXHIBIT 17

AKRON CENTER FOR REPRODUCTIVE HEALTH
DEMOGRAPHICS ON PARENTAL KNOWLEDGE
December 1977-July 1978

One or more parents (or legal guardian)—*Aware*

Total		10 wks	10 wks	11 wks	12 wks	(abortion not done) 12 wks
23	17 yrs	6	9	4	4	–
14	16 yrs	5	3	2	2	2
14	15 yrs	5	6	1	1	1
7	14 yrs	2	1	1	1	2
–	13 yrs	–	–	–	–	–

* * *

Seven month *combination* stats.
(Dec. 77 → July 31, 1978)

	Aware	*Unaware*
17	68	116
16	68	49
15	61	13
14	26	3
13	5	–
12	2	–

PLAINTIFFS' EXHIBIT 24

AKRON WOMEN'S CLINIC STATISTICS ON FIRST 650 PATIENTS May 1977

AKRON WOMEN'S CLINIC would like to share with you the results of a study of our first 650 patients. We intend to study the demographic characteristics of our patients on a regular basis and to keep you informed of these results, and of our clinic's news. If you do not wish to be on our mailing list, please inform us. If you know of someone who would like to receive our newspaper or our brochures, do let us know.

* * *

Complication Rate

We intend to be honest about our complication rate. However, we only have reliable statistics on patients who are treated by our physicians. If you are a physician treating one of our patients with a problem related to the abortion procedure please inform us.

To date we have performed about 650 abortions. We are aware of a total of 5 patients who have been admitted to the hospital subsequent to the abortion. Of these, one was admitted for observation only and was released the following day without requiring further treatment, another was reaspirated under local anesthetic and discharged, another said she was admitted for an infection but then had a tubal ligation, and 2 required laparotomies for repair of a cervical and/or uterine perforation.

Hospital admission rate = .8%.

Four of our patients required reaspirations at our clinic. These are performed at no charge to the patients.

Outpatient reaspiration rate = .6%.

One of our patients was diagnosed as having a hydatidiform mole.

* * *

PLAINTIFFS' EXHIBIT 30

AKRON WOMEN'S CLINIC
INFORMATION SHEET REGARDING PREGNANCY

YOU THINK YOU'RE PREGNANT AND YOU'RE WONDERING WHAT TO DO . . .

You've missed your menstrual period (or had one lighter than usual which happens to some women when they're pregnant) and maybe you have some of these feelings:

you're just too tired, breasts are sore, sick to your stomach, hungry like never before, or "it feels just like it did those other times".

Find out if you really are pregnant (once in a while it's something else).

What To Do . . . .

For *$2.00* we have a test that works *32* days from the first day of your last period. For a *free* pregnancy test count *42* days from the first day of your last regular period (your period is now two weeks late), take your first urine sample of the day in a clean jar (refrigerate it and keep it cold) and bring it to us. We will give you the test results the same day.

If the results are negative, have it run again in 1-2 weeks or see your doctor, or both. Do find out what's causing your period not to come!

If the results are positive, you are pregnant. Now is the time to make your decision about pregnancy!

What are your choices?

Carry it full term and mother the child. See your doctor or health center for good medical care.

Carry it full term and plan for its adoption. See your doctor and decide on a referral agency, or ask us for recommendations.

Have the pregnancy terminated at our reliable abortion clinic. Everything is strictly confidential at Akron Women's Clinic. Excellent counseling is available if you want help in making your decision. We believe the *best* decision is the one you want for yourself. There is *no charge* for decision-making counseling.

If you're choosing an abortion, try to make plans as quickly as possible. Early terminations are safer, simpler, and less expensive than later procedures.

Read what an abortion is like. Turn this sheet over.

* * *

PLAINTIFFS' EXHIBIT 32

AKRON WOMEN'S CLINIC
PATIENT INFORMED CONSENT FORM

AKRON WOMEN'S CLINIC
513 West Market Street
Akron, Ohio 44303
(216) 535-6178

INFORMED CONSENT TO TREATMENT ANESTHETIC, AND OTHER MEDICAL SERVICES

Patient Name:

Date:

State Law requires us to obtain your consent to your contemplated surgical procedure. What you are being asked to sign is simply a confirmation that we have discussed your contemplated medical procedure and that we have given you sufficient information upon which to make a decision whether to have the procedure performed of your own free will. We wish to inform you, not to alarm you. If you wish, we can go into more elaborate details of more unlikely problems that are not contained in this form. If you do not, that is also your privilege. Please read the following form carefully and ask any questions that you may have before signing it.

1. I, _____
am _____ years old, and request and consent to the performance upon me of a pregnancy termination procedure, vacuum aspiration, at Akron Women's Clinic, by Dr. _____, or a designated associate physician.

2. I further consent to the taking of cultures and the performance of reasonably indicated tests and procedures in addition to pregnancy termination, whether or not relating to presently known conditions, if my medical attendants find these necessary or advisable in the course of evaluation or treatment, for management of complications or otherwise.

3. I have fully and completely disclosed my medical history, including allergies, blood conditions, prior medications, or drugs taken, and reactions I have had to anesthetics, medicines, or drugs. I consent to my physician's relying on this disclosure as complete.

4. I consent to the administration of such anesthetic as may be deemed necessary or advisable by my physician or associates. Local anesthetics do not always eliminate all pain, and in a small number of cases local anesthetics cause severe reactions or even shock, and no guarantees to the contrary have been made to me.

5. The first day of my last menstrual period was _____, 19___. This period was (check one) ___ normal, ___ heavy, ___ light. The period before it was ___ normal, ___ heavy, ___ light. My periods in the past six months have been ___ regular, ___ irregular, ___ other. If "other", describe: _____

_____

_____.

I understand that information concerning my last period is important to diagnosis and method of treatment, and I consent to treatment based upon my recollection as stated above, or upon findings from examination.

6. I understand that tissue and parts from inside the uterus will be removed during the procedure, and I

consent to their disposal or use by the clinic and/or physician in the manner they deem appropriate.

7. I fully understand that the purpose of the procedure is to terminate this pregnancy, and I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term. No one has coerced or compelled me to make this decision.

8. I understand that the complications associated with pregnancy termination are generally much less severe than with childbirth. Nonetheless, I realize there are inherent risks of minor and major complications which may occur in this as in all surgical procedures, without the fault of the physician. No guarantees have been made to me. I understand the possibility of perforation of the uterus and internal injuries resulting therefrom. I understand the possibility that not all of the tissue will be removed, that fever may occur, that bleeding may occur during or after the procedure, that infection may occur, that I may react badly to medicines or the anesthetic, that I may have pain, cramps, or even convulsions. I also realize the possibility of blood clots forming. Some of the complications may result in sterility as may repeated abortions. Though extremely rare, I realize that some complications could even lead to death. I further realize that I may need to be hospitalized for treatment of such complications and that operative procedures such as Dilation and Curetage and/or Hysterectomy may be necessitated at that time. I am fully aware that I will incur the cost of such hospitalization or treatment.

9. If I accept birth control I understand I may also have a mild or severe reaction to the contraceptive method.

10. I understand the importance of follow-up care and agree that I will arrange to have a pelvic examination by a qualified physician not sooner than 10 days nor later than 21 days following the pregnancy termination procedure.

11. I understand that any questions I have will be answered by my physician, nurse, and/or counselor, and I will ask such questions before leaving the facility.

12. If I have questions or complications after leaving, I agree to call the physician or clinic at (216) 535-6178 immediately.

13. I further understand that the medical practice of my physician is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the United States.

14. I agree that the consent given herein shall be binding upon myself, my heirs, executors, administrators, and assigns.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMED CONSENT, AND THAT I AGREE IN LIGHT OF THAT CONSENT TO THE PREGNANCY TERMINATION I HAVE REQUESTED. I ACKNOWLEDGE THAT ALL INFORMATION REGARDING THE NATURE, PURPOSE AND RISKS OF THE PREGNANCY TERMINATION HAVE BEEN DISCLOSED TO ME AND THAT ALL QUESTIONS ASKED HAVE BEEN ANSWERED IN A SATISFACTORY FASHION.

DATED: _____

_____ _____

Physician Signature of Patient

_____

Witness

I/We the undersigned, being the parent(s) or legal guardian(s) of the above named patient, certify that I/we have read the above consent to abortion and/or pregnancy termination; that I/we fully understand the contents thereof and do hereby give my/our authorization and consent to the performance of the surgical procedure described therein on the above named patient. I/we understand that part of the professional services includes birth control information and counseling, a month's supply of birth control pills, if she desires, plus a prescription for birth control pills at her three (3) week check-up.

Witness: _____

_____ _____

PLAINTIFFS' EXHIBIT 37

WOMENCARE
PATIENT INFORMED CONSENT FORM

WOMENCARE, INC.
759 West Market Street
Akron, Ohio 44303

The nature and purposes of an abortion, and the possibility of complications have been fully explained to me.

The complications include:	*The risks of these complications include:*
Infection	Hospitalization
Hemorrhage	Transfusion
Drug Sensitivity	Additional operation
Perforation of Uterus	Removal of uterus and subsequent loss of childbearing
Incomplete Abortion	Death
Continued Pregnancy	Continuing the pregnancy which may be damaged

I authorize appropriate disposal of tissue removed, including pathological examination. I confirm to the best of my knowledge, that my Last Menstrual Period (_____) is accurate and true.

I understand that it is my responsibility to take my medications as directed, to bring to the attention [the clinic] any unusual symptoms following the abortion.

I certify that I have read and fully understand the purposes of an abortion, the risks involved, and that no promise has been made that I will have no problems as a result of the abortion. The explanations referred to

were made and all blanks or statements requiring insertion or completion were filled in. All my questions have been answered to my satisfaction.

I understand that if I should have a complication, it may become necessary to involve my family.

_____

Signature

_____ Date

_____

Signature of Parent (Legal Guardian)

_____ Phone

_____

Address

_____ Date

_____

Witness

_____ Date

PLAINTIFFS' EXHIBIT 45

CHAPTER 3701-47, "ABORTIONS" OHIO ADMINISTRATIVE CODE

ABORTIONS

Note: Chapter 3701-47 of the Administrative Code was filed pursuant to Chapter 119 of the Revised Code.

* * *

3701-47-01 Definitions

As used in rules 3701-47-01 to 3701-47-07 of the Ohio Sanitary Code;

* * *

(E) "Fetus" means the developing conceptus from fourteen (14) weeks after the first day of the woman's last menstrual period until birth.

* * *

3701-47-07 Counseling

(A) The fact of the availability of both pre-abortion and post-abortion counseling for herself and other persons of her choosing shall be made known by the physician, to each woman who is seeking the abortion of a fetus.

(B) Counseling shall be non-judgmental, regardless of the circumstances of the pregnancy, but shall not be forced upon the woman.

(C) The woman shall be treated in a safe, humane and dignified manner during the counseling period and throughout her stay at the place where the abortion is performed.

* * *

PLAINTIFFS' EXHIBIT 46

AKRON CITY HOSPITAL
ABORTIONS—ELECTIVE AND THERAPEUTIC

A. TOTAL ABORTIONS PERFORMED:

In patient May 1977 thru February 1978 (March & April not available)	14
Out patient May 1977 thru April 1978	58

B. NUMBER PERFORMED IN EACH TRIMESTER:

	1st Trimester	2nd Trimester	3rd Trimester
In patient	8	6	0
Out patient	58	0	0

C. NUMBER CLASSIFIED AS THERAPEUTIC:

In patient (5 of these were for removal of dead fetus)	10
Out patient	4

D. METHOD USED:

	Suction	Suction & Curretage	Saline	Saline & Curretage	D&C	Hysterotomy
In patient		5	3	4	1	1
Out patient	16	19	1		22	

E. NO—UNKNOWN

F. NO—UNKNOWN

G. NO—UNKNOWN

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PLAINTIFFS' EXHIBIT 48

STATEMENT BY C. WILLIAM KECK, M.D., M.P.H., TO AKRON CITY COUNCIL HEALTH & SOCIAL SERVICE COMMITTEE, DATED FEBRUARY 4, 1978, WITH ATTACHED ARTICLE

HEARING
HEALTH AND SOCIAL SERVICE COMMITTEE
AKRON CITY COUNCIL

PROPOSED ABORTION ORDINANCES

February 4, 1978

By: C. William Keck, M.D., M.P.H.
Director of Health
Akron Health Department
177 South Broadway
Akron, Ohio 44308

Mr. Goehler and members of the Committee, I want to thank you for the opportunity to comment on the proposed abortion legislation now before you. As you know, my name is Dr. C. William Keck and I'm the Director of the Akron Public Health Department.

The ordinances in question propose to regulate the functioning of abortion clinics and other surgical facilities in the City of Akron where procedures are performed that have "an inherent risk to the life or health of the patient comparable to that of abortion". All surgical facilities are included, but hospitals are included only for the regulation of abortions and they would not be required to have a City license. According to the proposed ordinances, the responsibility of the Akron Department of Health would include:

(1.) the promulgation of rules and regulations governing each procedure fitting the risk definition,

including the delineation of which surgical procedures might be exempted from the standards of the ordinance and which must be included.

(2.) making available to all licensed physicians performing abortions in the City of Akron constructive notice forms, consent forms in triplicate, abortion report forms, complication report forms, and a list of public and private agencies available to assist a woman during pregnancy if she chooses not to have an abortion.

(3.) collecting all abortion and complication reports and collating and evaluating data contained therein.

(4.) inspecting all surgical facilities covered by the ordinance biannually, and reviewing their medical records and facilities.

(5.) licensing all surgical facilities covered by the ordinance and collecting license fees.

(6.) holding hearings to determine why a license should not be revoked from a facility in violation of the ordinance.

It becomes rapidly apparent that the Akron Health Department would be the major instrument intended to carry out the parameters of the proposed ordinances should either be adopted, and it's on that basis that I would like to speak on two major issues, the necessity for regulation of abortion facilities and the realities of what regulation of other surgical procedures of comparable risk to abortion would mean to my Department and this City's government.

I think it's appropriate to begin by stating that health departments have long played a role in regulating facilities where their operation has been shown to provide a

measurable threat to the public's health. Examples in the Akron area would include restaurants, where the potential for spread of infectious disease is high, and plasma collection centers where inordinate hepatitis transmission has occurred in the past. Indeed, the Health Commission of the City of Akron, through the Health Department and its Director, currently has full authority to deal with all matters concerning the public health and sanitation, including the regulation of medical and surgical facilities if the need were shown to exist (See Section 79 of the Charter of the City of Akron). In other words, if a medical necessity for regulation of abortion or other surgical facilities existed, a new ordinance would not be necessary to attempt to deal with that health problem, even though the Akron Health Department has not been traditionally involved in regulating private medical practice.

As you know, I've not approached the Health Commission with the suggestion that they should consider the formal regulation of abortion facilities. I have not done that because I don't believe that the medical necessity for regulation suggested by the proposed ordinances exists in Akron, and I think it important that I outline for you the reasons for that belief. I know that the Committee has listened to many hours of testimony from a number of experts, often presenting conflicting points of view, and, in some areas, without presenting appropriate corroborative data. My position is based on what I believe is a sound data base. I've summarized it below, and have also included a bibliography at the end of the text as well as copies of the most salient articles. That will allow you to peruse them at your leisure to assure yourself of the accuracy of my summation and to have available to you other pertinent information that

I've not summarized in the text. The major points of my position are as follows:

1. Once a woman becomes pregnant, there are only two conscious choices possible for her to make relative to the outcome of that pregnancy; carrying the pregnancy to term or aborting the pregnancy. Each choice carries its own inherent risk.

2. Abortion is a relatively simple and legal surgical procedure performed by duly licensed specialist physicians in the Akron area.

3. Abortion, particularly 1st trimester abortion, carries with it a low risk of death, a lesser risk of death to the woman involved than carrying a pregnancy to full term, and a risk of death that has been diminishing over the past few years. I refer to data principally from the Joint Program for the Study of Abortion/Center for Disease Control (JPSA/CDC)—an ongoing prospective study of legally induced abortions in the United States that I believe constitutes the largest study of abortion reported to date.

* * *

4. Legal abortions in abortion clinics have been available in Summit County since late 1976. There has been one maternal death in Summit County during that period due to amniotic fluid embolism after delivery of a live infant. There have been no maternal deaths related to legal abortions.

Table IV(4)
Maternal mortality from all causes (including legal abortion) in Summit County by year

Year	*No. of Maternal Deaths*
1971	0
1972	0
1973	0

Year	*No. of Maternal Deaths*
1974	1
1975	0
1976	0
1977[5]	1*

* Applies to Akron only.

5. Morbidity rates associated with abortion, particularly during the first trimester, are relatively low in the United States, and lower than the United States average in the Akron area.

MORBIDITY

Table V[6]

Rate of complications per legal abortions done by suction curretage during the 1st trimester JPSA/CDC, 1971-1975

	Weeks of Gestation		
Rates	*8*	*9-10*	*11-12*
Total morbidity rate*	4.55	4.81	5.47
Major morbidity rate†	0.23	0.36	0.44

* Includes nearly 100 potentially codable complications, covering even such relatively minor complaints as breast engorgement and vaginitis.

† Includes the following 15 major complications: Cardiac arrest; convulsions; death; endotoxic shock; fever for 3 or more days; hemorrhage necessitating blood transfusions; hypernatremia; injury to bladder, ureter or intestines; pelvic infection with 2 or more days of fever and a peak of at least 40° C, or with hospitalization for 11 or more days; pneumonia; ostcgiatric hospitalization for 11 or more days; pulmonary embolism or infarction; thrombophlebitis; unintended major surgery; and wound disruption after hysterotomy or hysterectomy.

Table VI[7]

Number of abortions and complications, and rate of complications per 100 legal abortions done during the 1st trimester in Akron's four abortion clinics during 1977

Abortions Done	5,574	
Total Complications	40	
Major Complications	1	(Convulsion in an epileptic)
Total Morbidity Rate	0.71	
Major Morbidity Rate	0.02	

Note: Information was not requested by week of gestation. Many of the very minor complications (e.g., breast tenderness) counted in the JPSA/CDC study were not counted in Akron so the total morbidity rate above, while appropriate for here, is artifically low compared to the National figures in Table V. The major morbidity rates are comparable, however, except that the National figures are more than two years old and may very well be lower now. In any case the Akron rate could hardly be lower.

6. The State of Ohio currently regulates abortion facilities in the City of Akron.

7. There have been few medical problems associated with the operation of Akron's abortion facilities. Several complaints have been investigated by the Akron Health Department and the Summit County Medical Society. They had either no apparent substance or were easily resolved. There have also been no medical malpractice suits in Akron about abortions.

In summary, then, I must suggest to the Committee that from the point of view of protecting the health of the woman involved there is no compelling reason to regulate Akron's abortion facilities. If data exists of sufficient quality to contradict that which is available to me, I'd be pleased to evaluate it. I only hope it would come in sufficient detail to permit careful analysis from an epidemiological point of view.

The second major issue I'd like to address is the provisions of the second abortion ordinance submitted to City Council for consideration that deal with the licensure and regulation of surgical facilities where procedures are performed that have "an inherent risk to the life or health of the patient comparable to that of abortion". The potential impact of that provision on the Department of Health is so staggering that I find myself somewhat at a loss in deciding how to approach the whole area. Let me begin by discussing the need for such an approach, follow that with a brief discussion of what would be necessary in order for the Health Department to comply with it and end with my views of what the impact of an effort like this would be.

Try as I may, I cannot discern a health problem that would require such an effort for its resolution. We all happen to live in an area whose overall medical capacity in terms of facilities, equipment and personnel is quite excellent. We have a new medical school which is stimulating further excellence and a Health Systems Agency and Goals for Greater Akron Health Task Force that have both spent years looking at our local health care delivery system without ever suggesting in their health plans the existence of a problem in quality of delivery of health care that would require this kind of activity for its resolution. Nor have recent Health Department community diagnosis and priority planning efforts identified a need to regulate outpatient surgical procedures executed by competent, licensed practitioners.

* * *

When you realize that there are 268 physician and dentist subspecialists practicing in Akron who may perform one or more of many surgical procedures in their offices with risk comparable to abortion (see Table VII),

you can begin to realize the potential size and nature of such an undertaking. The Health Department has no real expertise in these clinical subspeciality areas—we would have to hire it. The Health Department has no inspectors with free time who could be trained to do inspections—we would have to hire them. The Health Department has no infrastructure to handle the clerical needs of such an effort, we would have to create it. The cost in dollars would be staggering, and the potential licensure income of approximately $25,000 would barely scratch the surface of those costs. The Non-Institutional Services Division of the Ambulatory Health Care Program of the Ohio Department of Health which inspects agencies for Medicaid that deliver home nursing care just determined that, including all administrative and inspectional costs, it costs $1,500.00 to make *one* agency inspection. Costs of that magnitude multiplied by an unknown number of procedures done by dozens of facilities lead quickly into a range of hundreds of thousands of dollars per year. Even if money in large amounts was immediately available, it could easily take a year or more for the first license to be issued. There would be other costs as well. Such an effort would sap the energy of a significant portion of the Health Department managerial team; a carefully engineered Management by Objectives and Results system and its structure of public health priorities would fall by the wayside to deal with inappropriate priorities; an unnecessary antagonistic mileu would be created between City government and the medical community; and the Health Department's effectiveness as a regulatory agency would be seriously damaged, to name just a few. In actuality, I think we would quickly find many provisions of the ordinance impossible to fulfill.

PLAINTIFFS' EXHIBIT 47

AKRON GENERAL MEDICAL CENTER REPORT ON ABORTIONS
August 25, 1978

OUTPATIENT ABORTIONS

Date	*Elective*	*Therapeutic*	*First Trimester*	*Method*
May 1977	4	1	5	Suction Curettage (5)
June 1977	3	0	3	Suction Curettage (3)
July 1977	1	0	1	Suction Curettage (1)
August 1977	0	0	0	0
September 1977	3	0	3	Suction Curettage (3)
October 1977	3	0	3	Suction Curettage (3)
November 1977	2	0	2	Suction Curettage (2)
December 1977	3	0	3	Suction Curettage (3)
January 1978	0	0	0	0
February 1978	6	2	8	Suction Curettage (8)
March 1978	1	0	1	Suction Curettage (1)
April 1978	2	0	2	Suction Curettage (2)
Total	28	3	31	31

/s/ Nancy L. Walker, A.R.T.
Acting Medical Record Administrator

INPATIENT ABORTIONS

Date	*Elective*	*Therapeutic*	*1st Trimester*	*2nd Trimester*	*Method*
May 1977	0	0	0	0	0
June 1977	0	0	0	0	0
July 1977	1	0	1	0	Suction Curettage
	1	0	1	0	Hysterotomy
August 1977	3	0	3	0	Suction Curettage (3)
September 1977	2	0	2	0	Suction Curettage (2)
	0	1	0	1	Saline Injection
	0	1	1	0	Dilatation & Curettage
	0	1	0	1	Dilatation & Curettage
October 1977	2	0	2	0	Suction Curettage (2)
November 1977	1	0	1	0	Suction Curettage
December 1977	4	0	3	1	Suction Curettage (4)
January 1978	0	0	0	0	0
February 1978	4	0	4	0	Suction Curettage (4)
	0	1	1	0	Abdominal Hysterectomy

***Inpatient Abortions**, continued:*

Date	*Elective*	*Therapeutic*	*1st Trimester*	*2nd Trimester*	*Method*
March 1978	2	0	2	0	Suction Curettage (2)
April 1978	1	0	1	0	Suction Curettage
	0	2	2	0	Suction Curettage (2)
Total	21	6	24	3	27

Total number of cases by Method — Suction Curettage — 22
Hysterotomy — 1
Saline Injection — 1
Abdominal Hysterectomy — 1
Dilatation & Curettage — 2
27

/s/ Nancy L. Walker, ART
Acting Medical Record Administrator

The impact of such an effort could only be a negative one. The authority to regulate in the area of public health needs is a powerful tool for correcting public health problems that won't respond to other measures. To regulate without cause is a flagrant misuse of regulatory authority and would not, in this instance, improve our health care delivery system.

Table VII
Physicians and dentists within the City of Akron who may perform surgeries outside the hospital

Cardiovascular Surgery	7
Dermatology	7
Diagnostic Radiology	7
Eye, Ear, Nose & Throat	1
Ear, Nose & Throat	0
Gynecology	2
Gynecologic Oncology	1
General Surgery	29
Industrial Surgery	1
Oncology	2
Obstetrics & Gynecology	36
Occupational Medicine	9
Ophthalmology	13
Orthopaedic Surgery	26
Otolaryngology	6
Otorhinolaryngology	2
Pediatrics	18
Pediatric Cardiology	2
Pediatric Surgery	3
Pediatric Urology	1
Pediatric Orthopaedic Surgery	1
Proctology	1

Plastic Surgery	9
Radiology	22
Reconstructive Surgery	3
Traumatic Surgery	0
Thoracic Surgery	6
Vascular Surgery	3
Urology	13
Oral Dental Surgeons	11
Podiatry	23
Osteopathy—Obstetrics	1
Osteopathy—Surgery	2
	268

* * * My suggestion to the Committee and City Council is that from the point of view of the health of the woman there is no demonstrable medical need for action and the surgical facility regulation provisions are unnecessary and basically unworkable. I believe City Council would be ill advised to pass either of these abortion ordinances.

1. THE EFFECT OF DELAY AND METHOD CHOICE ON THE RISK OF ABORTION MORBIDITY

By Willard Cates, Jr., Kenneth F. Schulz, David A. Grimes and Carl W. Tyler, Jr.

* * *

Relative Risks of Delay and Methods

Within the first 12 weeks, the main risk to a woman who wants an abortion results from delay. Both total and major morbidity rates are lowest when abortions are performed by suction curettage at eight or fewer menstrual weeks' gestation (see Table 2). The total

complication rate for suction curettage performed at eight or fewer weeks is 4.55 per 100 abortions, compared with 4.81 and 5.47 if the same procedure is delayed until the next two intervals (9–10 and 11–12 weeks). Thus, the total morbidity rate increases by 20 percent when abortion is delayed from the eighth to the twelfth week of gestation.

The major complication rate is 0.23 per 100 abortions for suction curettage at eight or fewer weeks, compared with 0.36 in the 9–10-week interval and 0.44 if the patient waits until the 11–12-week interval. Thus, the major complication rate increases 91 percent when abortion is postponed from the eighth to the twelfth week.

* * *

Intillation procedures, whether using saline or PCF_{2a} as the abortifacient, were associated with significantly higher total and major morbidity rates than abortions performed by uterine evacuation techniques. The total complication rate associated with abortions performed by saline instillation was higher during the first weeks of the second trimester than for terminations performed after the sixteenth week. The major morbidity rates for saline induction increased with length of gestation; however, this was an inconsequential increase. Instillation of PCF_{2a} was associated with total and major complication rates that were higher than those associated with saline instillation during both of the gestational intervals studied.

* * *

1. Delay

Our findings clearly demonstrate that *any* delay increases the risk of complications to a pregnant woman who wishes an abortion. Moreover, this risk appears to increase continuously and linearly as the length of

gestation increases. Considering D&E an extension of the uterine evacuation procedures used at 12 weeks or less, the risk of complications in the 13-16-week interval increases at a rate similar to that in the earlier period. Through 16 weeks' gestation, we have shown conceptually how even one week's delay (at whatever stage of gestation the woman initially requests her abortion) will add increased risks.

Previous reports on the correlates of abortion delay have focused on differences between women seeking first- and second-trimester abortions. However, based on the above reasoning, we feel this differentiation by trimesters is arbitrary and can be misleading. Our data show that a two-week delay between the ≤8 and 9-10-week intervals is just as dangerous as a similar delay between the 11-12- and 13-16-week intervals. We believe that gestation as a risk factor should be viewed as a *continuum* and not in terms of arbitrary stratifications, and that public education should emphasize that the earlier a woman can obtain an abortion, the lower her risks.

* * *

2. Choice of Method

JPSA/CDC reveals that in those institutions studied, the method chosen for later abortions affected both total and major morbidity.[10] D&E was more than 160 percent safer than saline instillation, which in turn was 60 percent safer than PGF_{2a} instillation. Both these differences were statistically significant ($p < 0.01$), and remained significant even after standardizing for age of patient, gestational age, preexisting conditions, level of operator training, prophylactic antibiotics and patient follow-up. Therefore, our study documents that D&E *can* be relatively safe, and perhaps it is time to train

specialists in D&E procedures so that this method will be available in selected facilities everywhere.

Acceptance of the relative safety of midtrimester D&E will reduce complications from abortion in two ways: First, the method itself appears to be safer; and second, there will be no need for the traditional waiting period. Current clinical teachings often advise women seeking abortion who are 13–15 weeks pregnant to wait another 2–4 weeks until the uterus is large enough for abdominal amniocentesis.[11] This delay is not necessary, however, if D&E is used to terminate pregnancies at the time the women seek their abortions. Extrapolating from JPSA/CDC to national data, we estimate that less than one percent of all abortions would be performed at more than 16 weeks if no waiting period were imposed, and that 90 percent of all instillation procedures would be replaced by D&E procedures between the thirteenth and sixteenth weeks.

Finally, our model provides a summary for both health professionals and patients of the risks of complications inherent in delay and in choice of abortion method. We hope that an awareness of these cumulative risks will lead to a reduction of delay in seeking abortion, and an increase in the choice of the safest method.

* * *

PLAINTIFFS' EXHIBIT 50

STATEMENT ON ABORTION ORDINANCES BY DR. CHARLES BOWEN, SPEAKING FOR THE SUMMIT COUNTY MEDICAL SOCIETY

I am Dr. Charles Bowen and I am engaged in the private practice of Obstetrics and Gynecology. I am representing the Summit County Medical Society Council as secretary and as a member of the Maternal and Infant Health Committee of Summit County Medical Society (SCMS).

After the Supreme Court ruling on abortions in 1973, the SCMS Council approved guidelines for the supervision of non-therapeutic abortion clinics drawn up by the Maternal & Infant Health Committee and the Public Health Committee of SCMS realizing that the enforcement of these guidelines could be difficult. However, since the local abortion clinics have opened they have voluntarily allowed an audit and review committee of the SCMS and the Akron Health Department and the Akron Ob-Gyn Society to enter their clinics. The initial reviews were carried out by Doctors Estep, Keck and Bowen in June 1977. There have been a few deficiencies in the different clinics that had been corrected by the time we had a follow-up inspection. The Planned Parenthood Association also insists on inspecting the clinics before they will refer patients. Their inspection is thorough on all aspects mentioned in the ordinance. The few complaints SCMS has received from patients of the abortion clinics were all thoroughly investigated and settled to everyone's satisfaction.

Therefore, there is no medical need for an ordinance to be introduced.

The SCMS really became concerned when the amended ordinance would have control of abortion clinics and all

comparable surgical clinics. There is no doubt this would be an interference in the private practice of medicine. No third party is allowed to invade the privacy of the physician-patient relationship. The tendency for government interference at all levels into the practice of medicine has become alarming in the past few years.

The Ohio Medical Practice Act as amended in 1969, is the legislation which placed the authority over the practice of medicine and surgery in the hands of the Ohio Medical Board. In the Medical Practice Act sections 4730.01 thru section 4731.99 gives the Ohio Medical Board the authority to regulate the practice of Medicine and Surgery and eleven other limited branches of health practice. This authority is not given to any other level of government in the state. The SCMS was not asked for any professional advice by the proposers of this ordinance.

The physicians of the SCMS are only interested in making sure that all abortion clinics in Summit County are well run from a medical viewpoint and up to this point in time the abortion clinics are doing an adequate job.

The ordinance seems to indicate that the Health Department under Dr. Keck, would develop an ongoing medical audit of all comparable surgical clinics. This is not necessary and as a tax payer I would certainly be interested in knowing the cost of such a program which could include as many as 200 clinics. The Health Commission appointed by the mayor and approved by City Council should be able to do any regulating that may become necessary if we should fail.

The physicians of Summit County do not intend to be drawn into the debate as to whether elective abortions are right or wrong. However, when there is an attempt

to pass an ordinance to regulate abortion clinics which at the same time would infringe on the private practice of medicine we will take a strong, vigorous stand against that ordinance. We did not realize that the ordinance would be amended as it was or we would have spoken out against it much sooner.

City council proposed an ordinance on abortion clinics in October 1977, on which several physicians testified and on the advice of the law director, the ordinance was not passed.

The medical community recognizes that non-therapeutic abortions are legal. We believe that it is our responsibility to determine that the clinics are run ethically and that they will stand medical inspection for standards and quality.

PLAINTIFFS' EXHIBIT 51

STATEMENT BY AKRON MAYOR JOHN S. BALLARD, DATED MARCH 8, 1978, ON HIS DECISION TO ALLOW ORDINANCE NO. 160-1978 TO BECOME LAW WITHOUT HIS SIGNATURE

Although I have serious reservations about the abortion ordinance, I have decided to allow it to become law without my signature.

My reservations are based upon a failure to demonstrate that a need exists for further regulation. I understand that the State inspects the existing clinics under the Medicaid program to insure they meet adequate medical standards. I don't believe any credible evidence has been advanced to suggest that adequate and proper medical standards and procedures are being ignored in Akron.

Therefore, I don't believe it has been demonstrated, from a medical standpoint, that further regulation is necessary.

Further, it appears to me that the thrust of this ordinance may run counter to now well-established case law, in that it possibly invades constitutionally guaranteed rights of women who desire to have an abortion.

There has been considerable debate about the legality and constitutionality of the ordinance. I don't feel I should presume to decide these questions—the courts are the proper place for the resolution of questions of law.

If I veto the ordinance, the legal debate will no doubt go on *ad infinitum*. Without question, when the ordinance becomes law in 30 days, it will be challenged in the courts.

It appears to me that only through litigation will the matter be put to rest one way or the other with finality.

DEPOSITION OF MARVIN WEINBERGER

[39] Q. All right. Let's try to do it this way. You made a statement, in that article identified as Plaintiffs' Exhibit 5, that "These experts set out to devise an ordinance worthy of becoming a national model, and are convinced that they have succeeded in developing legislation which will fairly and constitutionally regulate abortion to protect the health and safety of the mother, while insofar as possible preserving the right to life of the unborn child."

Is that an accurate statement?

* * *

Q. Marvin made that representation in this article that that's what their interest was in assisting in drafting and reviewing the Akron ordinance, and I want to know if that's an accurate summary of their interest in the ordinance.

A. My perception of their interest—

Q. Yes?

A. —I think, can be fairly summarized as I summarized it in that article.

* * *

[40] Q. All right. Have you ever visited any of the three abortion clinics in Akron, visited, been on the premises, inside any of the clinics?

* * *

The Witness: I don't recall having ever entered into any of the three abortion clinics.

* * *

Q. Have you ever witnessed any counseling sessions in the clinic, in any of the three clinics?

A. If I have never visited any of the clinics—

Q. Yes or no?

A. No.

* * *

[41] Q. It seems pretty clear. Do you have any personal knowledge, through your own observations, not hearsay, of what somebody has told you about what goes on in the clinics, but through your own personal observations do you have any knowledge of the kinds of counseling or medical services available at the clinics?

* * *

[42] *The Witness:* No.

* * *

[98] Q. All right. Did you have any other basis of knowing about what went on in the clinics?

* * *

Beyond that, we had, on one occasion, a confidential witness appear before Councilman Goehler and some of the other people for our side, who worked at one of the local hospitals, who complained about specific problems that she had perceived in terms of physiological reactions to abortions that she had to treat.

Q. Now, is this before the committee on Health and [99] Social Services headed by Councilman Goehler?

A. Right.

Q. And was the entire committee there for that meeting?

A. For that particular meeting? I should correct myself, I don't believe it was a formal committee meeting. It was held outside of Council chambers because of the extreme concern of the particular party not to be identified for various reasons.

* * *

A. At this more or less informal meeting, I was there. We had—we—we, after having found out this person was interested in speaking, we—we made contact with committee and asked if they were interested in hearing from this person, or specifically Bob Goehler, and he agreed to take the time to come over and hear what this woman had to say.

* * *

OHIO REV. CODE ANN.
§§ 2151.03, 2151.04, 2151.05, 2151.23, 2151.33, 2317.54, 2919.12, AND 3109.04

§ 2151.03 Neglected child defined

As used in sections 2151.01 to 2151.54, inclusive, of the Revised Code, "neglected child" includes any child:

(A) Who is abandoned by his parents, guardian, or custodian;

(B) Who lacks proper parental care because of the faults or habits of his parents, guardian, or custodian;

(C) Whose parents, guardian, or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being;

(D) Whose parents, guardian, or custodian neglects or refuses to provide the special care made necessary by his mental condition;

(E) Whose parents, legal guardian, or custodian have placed or attempted to place such child in violation of sections 5103.16 and 5103.17 of the Revised Code.

A child who, in lieu of medical or surgical care or treatment for a wound, injury, disability, or physical or mental condition, is under spiritual treatment through prayer in accordance with the tenets and practices of a well-recognized religion, is not a neglected child for this reason alone.

§ 2151.04 Dependent child defined

As used in sections 2151.01 to 2151.54, inclusive, of the Revised Code, "dependent child" includes any child:

(A) Who is homeless or destitute or without proper

care or support, through no fault of his parents, guardian, or custodian;

(B) Who lacks proper care or support by reason of the mental or physical condition of his parents, guardian, or custodian;

(C) Whose condition or environment is such as to warrant the state, in the interests of the child, in assuming his guardianship.

§ 2151.05 Child without proper parental care

Under sections 2151.01 to 2151.54 of the Revised Code, a child whose home is filthy and unsanitary; whose parents, stepparents, guardian, or custodian permit him to become dependent, neglected, abused, or delinquent; whose parents, stepparents, guardian, or custodian, when able, refuse or neglect to provide him with necessary care, support, medical attention, and educational facilities; or whose parents, stepparents, guardian, or custodian fail to subject such child to necessary discipline is without proper parental care or guardianship.

§ 2151.23 Jurisdiction of juvenile court

(A) The juvenile court has exclusive original jurisdiction under the Revised Code:

(1) Concerning any child who on or about the date specified in the complaint is alleged to be a juvenile traffic offender, delinquent, unruly, abused, neglected, or dependent;

(2) To determine the custody of any child not a ward of another court of this state;

(3) To hear and determine any application for a writ of habeas corpus involving the custody of a child;

(4) To exercise the powers and jurisdiction given

the probate division of the court of common pleas in Chapters 5122. and 5123. of the Revised Code, if the court has probable cause to believe that a child otherwise within the jurisdiction of the court is a mentally ill person subject to hospitalization by court order, as defined in section 5122.01 of the Revised Code, or a mentally retarded person subject to hospitalization by court order as defined in section 5123.68 of the Revised Code;

(5) To hear and determine all criminal cases charging adults with the violation of any section of Chapter 2151. of the Revised Code;

(6) Under the interstate compact on juveniles in section 2151.56 of the Revised Code;

(7) To hear and determine applications for consent to marry pursuant to section 3101.04 of the Revised Code.

(B) The juvenile court has original jurisdiction under the Revised Code:

(1) To hear and determine all cases of misdemeanors charging adults with any act or omission with respect to any child, which act or omission is a violation of any state law or any municipal ordinance;

(2) To determine the paternity of any child alleged to have been born out of wedlock pursuant to Chapter 3111. of the Revised Code;

(3) Under the uniform support of dependents act in Chapter 3115. of the Revised Code.

(C) The juvenile court, except as to juvenile courts which are a separate division of the court of common pleas, or a separate and independent juvenile court, has jurisdiction to hear, determine, and make a record of any action for divorce or alimony involving the custody or care of children filed in the court of common pleas

and certified by the court of common pleas with all the papers filed therein to the court for trial, provided that no such certification shall be made to any court unless the consent of the juvenile judge is first obtained. After such certification is made and consent obtained, the court shall proceed as if such action were originally begun in said court except as to awards for alimony or support due and unpaid at the time of certification, over which the court has no jurisdiction.

(D) The juvenile court has jurisdiction to hear and determine all matters as to custody and support of children duly certified by the court of common pleas to the juvenile court after a divorce decree has been granted, including jurisdiction to modify the judgment and decree of the common pleas court as the same relate to the custody and support of children.

(E) The juvenile court has jurisdiction to hear and determine the case of any child certified to the court by any court of competent jurisdiction if such child comes within the jurisdiction of the court as defined by this section.

(F) The juvenile court shall exercise its jurisdiction in child custody matters in accordance with sections 3109.21 to 3109.36 of the Revised Code.

§ 2151.33 Temporary care; emergency medical treatment; reimbursement

Pending hearing of a complaint filed under section 2151.27 of the Revised Code and service of citations, the juvenile court may make such temporary disposition of any child as it deems best. Upon the certificate of one or more reputable practicing physicians, the court may summarily provide for emergency medical and surgical treatment which appears to be immediately necessary for any child concerning whom a complaint or an application

for care has been filed, pending the service of a citation upon its parents, guardian, or custodian. The court may order the parents, guardian, or custodian, if found able to do so, to reimburse the court for the expense involved in providing such emergency medical and surgical treatment, and any such person who disobeys such order may be adjudged in contempt of court and punished accordingly.

When such emergency medical and surgical treatment is furnished a child who is found at the hearing to be a nonresident of the county, and if the expense of such medical and surgical treatment cannot be recovered from the parents, legal guardian, or custodian of such child, the board of county commissioners of the county in which such child has a legal settlement shall reimburse the court for the reasonable cost of such emergency medical or surgical treatment out of its general fund.

§ 2317.54 [Consent to surgical or medical procedure; requirements.]

A hospital shall not be held liable for a physician's failure to obtain an informed consent from his patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not

able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and (C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term "hospital" has the meaning set forth in division (D) of section 2305.11 of

the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

§ 2919.12 Abortion without informed consent prohibited

(A) No person shall perform or induce an abortion without the informed consent of the pregnant woman.

(B) If the pregnant woman is an unmarried minor, the pregnant woman's consent must be accompanied by the informed consent of one of her parents or of her custodian or guardian.

(C) Whoever violates this section is guilty of consensual abortion, a misdemeanor of the first degree and for subsequent offense, a felony of the fourth degree; and is liable to the pregnant woman for civil compensatory and exemplary damages.

§ 3109.04 Court awarding custody; joint custody; modifications; best interests of child

Note: See also preceding amendment of this section by 1981 H 71, in effect until 3-15-82.

(A) Upon hearing the testimony of either or both parents and in accordance with sections 3109.21 to 3109.36 of the Revised Code, the court shall decide to whom the care, custody, and control of the children shall be given. The court may grant the care, custody, and control of the children to either parent or, if a request is made in accordance with division (D) of this section, to the parents jointly. The court shall take into account that which would be in the best interest of the children. The court may allow any child who is twelve years of age

or older to choose, in an original proceeding on custody and in a proceeding for modification of a prior custody order of the court, the parent with whom the child is to live, unless the court finds that the parent so selected is unfit to take charge or unless the court finds, with respect to a child who is twelve years of age or older, that it would not be in the best interest of the child to have the choice. The court shall not grant joint care, custody, and control of the children to the parents unless they request the grant of joint care, custody, and control pursuant to division (D) of this section.

If the court allows any child who is twelve years of age or older to choose the parent with whom the child is to live, the court shall offer the child the opportunity to inform the court of the choice in chambers or in open court. If the child elects to inform the court of the choice in chambers, no persons other than the child, the child's attorney, the judge, any necessary court personnel, and, in the judge's discretion, the attorney of each parent shall be permitted to be present in the chambers when the child informs the court of the choice and is questioned with respect to the choice.

Prior to trial, the court may cause an investigation to be made as to the character, family relations, past conduct, earning ability, and financial worth of the parties to the action and may order the parties and their minor children to submit to medical, psychological, and psychiatric examinations. The report of the investigation and examinations shall be made available to either party or his counsel of record not less than five days before trial, upon written request. The report shall be signed by the investigator and the investigator shall be subject to cross-examination by either party concerning the contents of the report. The court may tax as costs all or any part of the expenses for each investigation.

The court may order that the parents have joint care, custody, and control of the children only if both parents request joint custody and file a plan for joint custody pursuant to division (D) of this section and if joint custody is in the best interest of the children. Upon the filing of a plan requesting the joint care, custody, and control of the children, the court shall review the parents' plan for joint custody to determine if the plan is in the best interest of the children. If the court determines that the plan is in the best interest of the children, the court shall approve the plan. If the court determines that the plan or any part of the plan is not in the best interest of the children, the court shall require the parents to make appropriate changes to the plan to meet the court's objections to the plan. If changes to the plan are made to meet the court's objections, and if the new plan is in the best interest of the children, the court shall approve the plan. If changes or if the parents attempt to make changes to the plan to meet the court's objections, but the court determines that the new plan or any part of the new plan still is not in the best interest of the children, the court may reject the parents' request for joint care, custody, and control of the children and proceed as if the request had not been made. A plan approved by the court under this division shall be incorporated into a provisional joint custody decree granting the parents the provisional joint care, custody, and control of the children. The provisional joint custody decree shall clearly state that it is provisional, that it may be modified at any time prior to sixty days after the date of its issuance, and that it is subject to termination at any time prior to ninety days after the date of its issuance upon motion of either parent or, in certain situations, upon motion of the court itself, that if either parent or the court itself makes such a motion, the court

is required to terminate the provisional joint custody decree and proceed as if no request for joint custody ever had been made, and that if neither parent nor the court itself makes such a motion prior to the expiration of the niety-day [*sic*] period, the provisional joint custody decree immediately and without need for further action becomes final on the ninetieth day after the date of its issuance, subject to modification or termination authorized by this section. Any such provisional joint custody decree shall be appended to, but shall be separate and independent from and shall not affect the final decree of dissolution, divorce, separation, annulment, or alimony arising out of the action out of which the question of care, custody, and control arose.

If the court finds, with respect to any child under eighteen years of age, that custody to neither parent is in the best interest of the child, it may commit the child to a relative of the child or certify a copy of its findings, together with as much of the record and the further information, in narrative form or otherwise, as it deems necessary or that the juvenile court requests, to the juvenile court for further proceedings, and, upon the certification, the juvenile court has exclusive jurisdiction.

(B)(1) Except as provided in division (B)(2) of this section, the court shall not modify a prior custody decree unless it finds, based on facts that have arisen since the prior decree or that were unknown to the court at the time of the prior decree, that a change has occurred in the circumstances of the child, his custodian, or either joint custodian, and that the modification is necessary to serve the best interst [*sic*] of the child. In applying these standards, the court shall retain the custodian or both of the joint custodians designated by the prior decree, unless one of the following applies:

(a) The custodian or both joint custodians agree to a change in custody.

(b) The child, with the consent of the custodian or of both joint custodians, has been integrated into the family of the prson seeking custody.

(c) The child's present environment endangers significantly his physical health or his mental, moral, or emotional development and the harm likely to be caused by a change of environment is outweighed by the advantages of the change of environment to the child.

(2) In addition to the modification authorized under division (B)(1) of this section:

(a) Joint custodians may modify the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the joint custody decree. Modifications may be made under this division, in relation to a final decree, at any time, and in relation to a provisional decree, at any time prior to sixty days after the date of issuance of the provisional decree. The modifications to the plan shall be filed with the court, and the court shall include them in the plan, unless they are not in the best interest of the children, in which case the court may reject the modifications. Modifications submitted by the joint custodians shall be effective upon their inclusion by the court in the plan. A modification to a provisional plan madeunder [*sic*] this division does not affect or extend the ninety-day period during which the provisional plan may be terminated upon motion of either parent or the court itself.

(b) The court may modify the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the joint custody decree upon the request of one or both of the joint custodians. Modifications may be made under this

division, in relation to a final decree, at any time, and in relation to a provisional decree, at any time prior to sixty days after the date of issuance of the provisional decree. The court shall not make any modification to the plan, unless the modification is in the best interest of the children and the joint custodians agree to the modification. A modification to a provisional plan made under this division does not affect or extend the ninety-day period during which the provisional plan may be terminated upon motion of either parent or the court itself.

(c) The court shall terminate a provisional joint custody decree [*sic*] if either parent or the court itself makes a motion to terminate the provisional decree at any time prior to ninety days after the date of its issuance. The court itself may make a motion to terminate a provisional decree only if it has reason to believe that the plan incorporated into the provisional decree is not in the best interest of the children and that it cannot be modified so as to be in the best interest of the children or if it has reason to believe that joint custody itself is not in the best interest of the children. If the court has reason to believe that the plan incorporated into the provisional decree is not in the best interest of the children but that it can be modified so as to be in the best interest of the children, the plan may be modified in accordance with division (B)(2)(a) or (b) of this section regardless of whether the sixty-day period that normally applies in relation to modification of provisional decrees under those divisions has expired. If a provisional decree is terminated under this division, the court shall proceed in accordance with division (B)(2)(e) of this section. If neither parent nor the court itself makes a motion to terminate a provisional decree prior to the expiration of the ninety-day period, the provisional

decree immediately and without need for further action shall become final on the ninetieth day after the date of its issuance, subject to modification and termination authorized by this section.

(d) The court may terminate a prior final joint custody decree upon the request of one or both of the joint custodians or whenever it determines that joint custody is not in the best interest of the children. If modification of the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the final joint custody decree is attempted under division (B)(2)(a) of this section and the court rejects the modifications, it may terminate the final joint custody decree if it determines that joint custody is not in the best interest of the children. If the court proposes a modification to a final joint custody decree under division (B)(2)(b) of this section and the joint custodians do not agree to the modification, the court may terminate the final joint custody decree if it determines that joint custody is not in the best interest of the children.

(e) Upon the termination of a provisional joint custody decree or a prior final joint custody decree under division (B)(2)(c) or (d) of this section, the court shall proceed and issue a modified decree for the care, custody, and control of the chilren under the standards applicable under division (A) of this section as if no decree for joint care, custody, and control had been granted and as if no requrest for joint care, custody, and control had ever been made.

(C) In determining the best interest of a child pursuant to this section, whether on an original award of custody or modification of custody, the court shall consider all relevant factors, including:

(1) The wishes of the child's parents regarding his custody;

(2) The wishes of the child regarding his custody if he is eleven years of age or older;

(3) The child's interaction and interrelationship with his parents, siblings, and any other person who may significantly affect the child's best interest;

(4) The child's adjustment to his home, school, and community;

(5) The mental and physical health of all persons involved in the situation.

(D) The parents of any children may request the court to grant them joint care, custody, and control of the children in a proceeding held pursuant to division (A) of this section. If a request for joint care, custody, and control is made, the parents making the request shall file with the court a plan for their exercise of joint care, custody, and control of the children. The plan shall be filed with the petition for dissolution of marriage, if the question of care, custody, and control arises out of an action for dissolution of marriage, or, in other cases, at a time at least thirty days prior to the hearing of the issue of the care, custody, and control of the children. A plan for joint custody shall include provisions covering all factors that are relevant to the care, custody, and control of the children, including, but not limited to provisions covering factors such as physical living arrangements, child support obligations, provision for the children's medical and dental care, school placement, and visitation.

(E) "Joint custody" or "joint care, custody and control," as used in the Revised Code, means that the parents share, in the manner set forth in the parents' plan for joint custody that is approved by the court, all or

some of the aspects of physical and legal care, custody, and control of their children.

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Nos. 81-746, 81-854

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

CITY OF AKRON, et al.,
Petitioners,
vs.
AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Respondents

FRANCOIS SEGUIN, et al.,
Petitioners,
vs.
AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
and
CITY OF AKRON, et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENTS' CONSOLIDATED BRIEF IN OPPOSITION TO CERTIORARI

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328
(Counsel of Record)

GORDON BEGGS
American Civil Liberties Union
of Cleveland Foundation, Inc.
1223 West Sixth Street
Cleveland, Ohio 44113
(216) 781-6276

JANET BENSHOOF
American Civil Liberties Union
Foundation
132 West 43rd Street
New York, N.Y. 10036
(212) 944-9800

Attorneys for Respondents

QUESTIONS PRESENTED FOR REVIEW

1. Whether this Court should abandon the constitutional test it established in Roe v. Wade, 410 U.S. 113 (1973), to assess the constitutionality of regulations restricting abortions.

2. Whether a regulation (Section 1870.05 (B)) vesting parents or judicial officers with an absolute veto of the abortion decision and mandating, in conjunction with Ohio Revised Code Chapter 2151, parental notification in the case of every woman under the age of fifteen regardless of her best interests or maturity, is unconstitutional.

3. Whether an inflexible regulation (Section 1870.06(B)) mandating that the physician, upon threat of criminal penalty, recite to every patient seeking an abortion at least 44 lines of printed material including medically inaccurate, biased, and irrelevant information, is unconstitutional.

4. Whether an inflexible and procedurally vague regulation (Section 1870.06(C)) mandating that the "attending physician" upon threat of criminal penalty, in every case personally provide an oral recitation of risk and technique details to each woman seeking an abortion, is unconstitutional because it imposes severe psychological and economic burdens on women seeking abortions in Akron, Ohio.

5. Whether an inflexible regulation (Section 1870.07) mandating that every woman seeking an abortion wait at least twenty-four hours after she has signed an informed consent document before she can obtain an abortion, is unconstitutional because it imposes severe physical, psychological and economic burdens on women seeking abortions in Akron, Ohio.

6. Whether a regulation (Section 1870.16) mandating that fetuses be

disposed of in a "humane" manner is unconstitutionally vague.

PARTIES

The defendant City of Akron has failed to noté in its petition that the Mayor of Akron, the Director of Public Health of Akron and the Police Prosecutor of Akron are all parties to the present proceeding. All these public officials were named as defendants in the complaint filed in the District Court and pursuant to Supreme Court Rule 19.6 they remain parties to this proceeding.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED FOR REVIEW.....i

PARTIES.....iv

STATUTORY PROVISIONS INVOLVED.....xii

STATEMENT OF THE CASE.....1

A. History of the Legislation.....1

B. History of the Litigation.....3

C. The Facts Presented Prove that the Restrictions at Issue Would Substantially Burden Women Seeking Abortions in Akron, Ohio.....9

1. Section 1870.05(B), requiring parental or judicial consent and mandatory parental notification in the case of every minor under fifteen was proven to be unduly burdensome.....9

2. Section 1870.06(B) setting forth 44 lines of information the attending physician must recite to every woman, would substantially burden women seeking abortions in Akron and their physicians.....13

3. Section 1870.06(C) requiring that the "attending physician" personally inform each patient is phychologically and economically burdensome in Akron, Ohio, where there are few doctors who perform abortions.....16

4. The evidence overwhelming supports the Circuit Court's holding that Section 1870.07, mandating a twenty-four hour delay, burdens women seeking abortions in Akron, Ohio.....21

REASONS WHY THE PETITION SHOULD NOT BE GRANTED.....23

I. DEFENDANTS HAVE PREVIOUSLY CONCEDED THE UNCONSTITUTIONALITY OF ORDINANCE SECTIONS REGULATING MINORS AND IMPOSING VARIOUS RESTRICTIONS ON THE INFORMED CONSENT DIALOGUE.....23

II. THE DEFENDANTS AND INTERVENORS PRESENT NO SPECIAL AND IMPORTANT REASONS FOR THE GRANTING OF REVIEW.....24

A. There Is No Conflict Between the Decision in the Present Case and Any Decision of Another Court of Appeals.....25

B. The Decision of the Court of Appeals Is Consistent

with the Decisions of this Court.....30

1. The standard of review used by the Sixth Circuit is consistent with the standard of review of this Court.....30

2. The Court of Appeals' ruling is consistent with this Court's decisions concerning regulations restricting the availability of of abortions to minors.....34

3. The Court of Appeals' rulings is consistent with this Court's rulings concerning regulations interfering with the abortion decision-making process.....38

C. A number of the Questions Presented by Defendants Are of No General Importance.....42

III. REVERSAL OF THE DECISION OF THE COURT OF APPEALS WOULD LEAD TO CONFUSION IN THE DETERMINATION OF CASES INVOLVING ABORTION REGULATION AND WOULD PROMOTE AD HOC ADJUDICATION.....45

IV. THE LAPSE OF TIME HAS RENDERED INTERVENORS' CLAIMS MOOT.....47

CONCLUSION.....51

TABLE OF AUTHORITIES

CASES: Page

Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979), aff'd in part rev'd in part, 651 F.2d 1198 (6th Cir. 1981)...passim

Atherton Mills v. Johnston, 259 U.S. 13 (1922).....48

Bellotti v. Baird, 428 U.S. 132 (1976).....33

Bellotti v. Baird, 443 U.S. 622 (1979).....33,34,36,37

Boston Tow Boat Co. v. United States, 321 U.S. 632 (1944).....50

California v. Taylor, 353 U.S. 553 (1957).....23,24

Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).....41

Carey v. Population Services International, 431 U.S. 678 (1977).....31,34

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980).....26,28,46

Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1 (1972).....41

Colautti v. Franklin, 439 U.S. 379 (1979).....39,44

DeFunis v. Odegaard, 416 U.S. 312 (1974).....49

Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978) aff'd 440 U.S. 941 (1979).....39

Gertz v. Robert Welch, Inc., 418 U.S. 323 (1974).....47

H.L. v. Matheson, 450 U.S. ___, 101 S. Ct. 1164 (1981).....8,33,37

Harris v. McRae, 448 U.S. 297 (1980).....32,33

Henry v. City of Rock Hill, 376 U.S. 776 (1964).....32

Indianapolis School Commissioners v. Jacobs, 420 U.S. 128 (1975).....48

Magnum Import Co. v. Coty, 262 U.S. 159 (1923).....44,45

Maher v. Roe, 432 U.S. 464 (1977).....32

Mahoning Women's Center v. Hunter, 610 F.2d 456 (6th Cir. (1979), vacated and remanded on other grounds 447 U.S. 918 (1980).....43

Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848 (8th Cir. 1981)...15,16,26,28 29,37

Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (E.D. Pa. 1975), aff'd sub nom. Franklin v. Fitzpatrick, 428 U.S. 901 (1976).....26,44

Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1981)..26,28,29

Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976).....31,34,35,38,39

Roe v. Wade, 410 U.S. 113 (1973).....27,30,31,32

Sloan v. Lemon, 413 U.S. 825 (1973).....42,43

Thone v. Womens Services, P.C., 636 F.2d 606 (8th Cir. 1980), reversed and remanded U.S. ___, 69 L. Ed.2d 414 (1981).....26,31

Weinstein v. Bradford, 423 U.S. 147 (1975).....49

Winters v. New York, 333 U.S. 507 (1947).....45

Wynn v. Carey, 582 F.2d 1375 (7th Cir. 1978).....26,29

Wynn v. Carey, 599 F.2d 193 (7th Cir. 1979).....26

STATUTES AND ORDINANCES:

Akron Ordinance 160-1978 (Chapter 1870)..... passim

Ohio Revised Code Chapter
2151.....10,35

Ohio Sanitary Code Section
3701-47-06.....14,41

OTHER AUTHORITIES:

J. Katz, EXPERIMENTATION WITH HUMAN BEINGS, 540-588 (1972).....41

STATUTORY PROVISIONS INVOLVED

The City of Akron Ordinance involved is Ordinance Number 160-1978 (hereinafter referred to by its Akron Codified Ordinance designation, Chapter 1870). It provides in pertinent part:

CHAPTER 1870

* * *

1870.05 NOTICE AND CONSENT

(A) No physician shall perform or induce an abortion upon an unmarried pregnant woman under the age of 18 years without first having given at least twenty-four (24) hours actual notice to one of the parents or the legal guardian of the minor pregnant woman as to the intention to perform such abortion, or if such parent or guardian cannot be reached after a reasonable effort to find him or her, without first having given at least seventy-two (72) hours constructive notice to one of the parents or the legal guardian of the minor pregnant woman by certified mail to the last known address of one of the parents or guardian, computed from the time of mailing, unless the abortion is ordered by a court having jurisdiction over such minor pregnant woman.

(B) No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen (15) years without first having obtained the informed written consent of the minor pregnant woman in accordance with Section 1870.06 of this Chapter, and

(1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or

(2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

1870.06 INFORMED CONSENT

(A) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, given freely and without coercion.

(B) In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05 (B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows:

(1) That according to the best judgment of her attending physician she is pregnant.

(2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and physical examination and appropriate laboratory tests.

(3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including

pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

(4) That her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

(5) That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

(6) That numerous public and private agencies and services are available to provide her with birth control information, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(C) At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall, at least orally, inform the pregnant

woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

(D) The attending physician performing or inducing the abortion shall provide the pregnant woman, or one of her parents or legal guardian signing the consent form where applicable, with a duplicate copy of the consent form signed by her, and one of her parents or her legal guardian where applicable, in accordance with Paragraph (B) of this Section.

1870.07 WAITING PERIOD

No physician shall perform or induce an abortion upon a pregnant woman until twenty-four (24) hours have elapsed from the time the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have signed the consent form required by Section 1870.06 of this Chapter, and the physician so certifies in writing that such time has elapsed.

* * *

1870.16 DISPOSAL OF REMAINS

Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a humane and sanitary manner.

* * *

1870.18 PENALTY

(A) Whoever violates Sections 1870.02, 1870.03, 1870.04, 1870.05, 1870.06, 1870.07, 1870.08, 1870.10, 1870.14, 1870.15 or 1870.17 of this Chapter shall be deemed guilty of a misdemeanor of the first degree and punished as provided for in Section 698.02 of the Codified Ordinances of the City of Akron, Ohio, 1975.

(B) Whoever violates any other provision of this Chapter shall be deemed guilty of a misdemeanor of the third degree and punished as provided for in Section 698.02 of the Codified Ordinances of the City of Akron, Ohio, 1975.

* * *

All other relevant statutory material may be found in the Appendix to the petition for writ of certiorari of the City of Akron (No. 81-746) except for the relevant sections of Chapter 3701-47 of the Ohio Administrative Code which provide as follows:

3701-47-01 Definitions

As used in rules 3701-47-01 to 3701-47-07 of the Ohio Sanitary Code;

* * *

(E) "Fetus" means the developing conceptus from fourteen (14) weeks after the first day of the woman's last menstrual period until birth.

* * *

3701-47-06 Counseling

(A) The fact of the availability of both pre-abortion and post-abortion counseling for herself and other persons of her choosing shall be made known by the physician, to each woman who is seeking the abortion of a fetus.

(B) Counseling shall be non-judgmental, regardless of the circumstances of the pregnancy, but shall not be forced upon the woman.

(C) The woman shall be treated in a safe, humane and dignified manner during the counseling period and throughout her stay at the place where the abortion is performed.

STATEMENT OF THE CASE

A. History of the Legislation

On February 28, 1978, the Akron City Council, by a vote of seven to six, enacted Chapter 1870, a nine page, 19 section, compendium of regulations restricting the availability of abortions in Akron, Ohio.[1]

The process by which Chapter 1870 was prepared was marked by drastic departures from normal legislative procedure. Chapter 1870 is one of only two bills enacted in an eleven year period over the objection of the City Law Department that the legislation was, in large measure, unconstitutional. (J.A. 321-323;

1. The legislation enacted was specifically intended by its drafters as a "national model." (Deposition of Marvin Weinberg August 2, 1978.) Chapter 1870 contains a variety of regulations inapplicable to Akron including a prohibition of abortions in municipal hospitals (Section 1870.13) despite the fact that Akron has no such facilities and no intention to acquire them. (Joint Appendix filed in the Court of Appeals at 391-392.)

393-394)[2] Chapter 1870 is the only bill submitted for City Council consideration within at least a three year span drafted by partisan advocates rather than the City Law Department. (J.A. 319) Chapter 1870 is the only legislation in recent memory to have been considered after ex parte hearings from which both the public and legislators opposed to the bill were excluded. (A.E. 72-74) Chapter 1870 is the only piece of legislation ever adopted by the City of Akron to regulate a medical or surgical procedure. Finally, Chapter 1870 was adopted despite statements by the Akron Director of Health, Akron Mayor and Summit County Medical Society that there

2. Unless otherwise noted, citations are to the Joint Appendix (J.A.) or Appendix of Exhibits (A.E.) submitted to the United States Court of Appeals for the Sixth Circuit in this case.

was no medical or health-related need for such legislation.[3]

B. History of the Litigation

The present litigation was commenced

3. C. William Keck, Director of Health of the Akron Department of Health, and a named defendant in this action, stated that the complication rate for Akron clinics is below the national average (A.E. 18), that the rate of major complications in Akron "could hardly be lower" (A.E. 19) and that there has never been a death related to the operation of the Akron clinics. (A.E. 18) His conclusion, based on this and other evidence, was "that from the point of view of protecting the health of the woman involved there is no compelling reason to regulate Akron's abortion facilities." (A.E. 20)

Dr. Charles Bowen, the ranking member of the Maternal and Infant Health Committee of the Summit County Medical Society, reviewed and audited the plaintiff clinics. (A.E. 43) His conclusion on behalf of the Summit County Medical Society was that "there is no medical need for an ordinance to be introduced." (A.E. 44)

John Ballard, the Mayor of the City of Akron, and a named defendant in this action, reached precisely the same conclusion. In a press statement released on March 8, 1978, the Mayor stated that there was "a failure to demonstrate that a need existed for . . . regulation." (A.E. 46)

on April 19, 1978, before the Honorable Leroy Contie, Jr., United States District Judge for the Northern District of Ohio, Eastern Division. Plaintiffs sought both injunctive and declaratory relief from the restrictions imposed by Chapter 1870. On April 28, 1978, a temporary restraining order was granted. On May 16, 1978, the District Court permitted intervenors to proceed in this action solely "in their individual capacity as parents of unmarried daughters of childbearing age." Akron Center for Reproductive Health v. City of Akron, 479 F.Supp 1172, 1181 (N.D. Ohio 1979). Trial on the merits took place from September 5 to September 19, 1978.

On August 22, 1979, the District Court issued its decision holding Sections 1870.05(A) and (B) (restricting the availability of abortions to all

minors), 1870.06(B) (substituting a script for the informed consent dialogue), 1870.09 (authorizing warrantless searches), and 1870.16 (requiring "humane" disposal of fetal remains) unconstitutional. It upheld a number of sections including 1870.06(C) (counseling exclusively by the attending physician) and 1870.07 (twenty-four hour delay). It determined that plaintiffs were without standing to challenge several other sections of the ordinance.

All parties appealed to the United States Court of Appeals for the Sixth Circuit.[4] As noted by the Court of

4. The precise scope of intervenors' appeal is unclear because they filed their appellate briefs as both amici and appellants. In November of 1979, intervenors, in a brief submitted to the District Court concerning the award of attorneys fees, described their intervention as being confined to "those issues surrounding Section 1870.05, Notice and Consent, and those portions of Section 1870.06, Informed Consent, providing for informed consent of parents or legal guardians." (J.A. 862)

Appeals, Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1205 (6th Cir. 1981), defendants did not appeal the District Court's invalidation of Section 1870.05(A) and (B) (restricting the availability of abortions to all minors). Further, defendants specifically conceded that subsections (3), (4), and (5) of Section 1870.06(B) (substituting a script for the informed consent dialogue) were unconstitutional and requested that they be severed from the remainder of that section of the ordinance. Finally, while not conceding that Section 1870.06(C) (counseling exclusively by the attending physician) was vague, defendants and intervenors gave diametrically opposed interpretations of its meaning thereby substantiating plaintiffs' vagueness

claim.[5]

On June 12, 1981, the Court of Appeals affirmed the District Court determinations invalidating Sections 1870.05(B) (parental veto and mandatory notification for women under 15), 1870.06(B)(substituting a script for the informed consent dialogue) and 1870.16 ("humane"disposal). It reversed the District Court and held unconstitutional 1870.06(C) (counseling exclusively by the attending physician) and 1870.07 (twenty-four hour delay). The Court of Appeals also held that the District Court had used the wrong constitutional

5. Plaintiffs had asserted that Section 1870.06(C) was vague because it failed to inform the attending physician when to provide the mandated counseling. In defense of the section defendants asserted that the counseling had to be performed at least twenty-four hours in advance of the abortion. (Defendants' Brief of February 28, 1980 at 18) Intervenors reached precisely the opposite conclusion. (Intervenors' Brief of April 8, 1980 at 15)

standard in testing the various provisions of the ordinance. Finally, on the basis of H. L. v. Matheson 450 U.S. ____, 101 S. Ct. 1164 (1981), the Court of Appeals reversed, on standing grounds, the ruling of the District Court invalidating 1870.05(A) (requiring parental notification for minors 15-17).[6] Thereafter defendants and intervenors sought certiorari.

6. Circuit Judge Kennedy filed an opinion concurring in part and dissenting in part. She concluded that three of the five sections of the ordinance on which defendants and intervenors seek review were unconstitutional. (Section 1870.06(B) (script substituted for informed consent dialogue), Section 1870.07 (twenty-four hour delay), Section 1870.16 ("humane" disposal)) She urged the validation of one of the remaining two sections on standing grounds. (Section 1870.05(B) (parental veto and notification for women under 15)) Finally, she dissented on constitutional grounds only with respect to the invalidation of a single section. (1870.06(C) (requiring personal counseling by the attending physician)).

C. The Facts Presented Prove That the Restrictions at Issue Would Substantially Burden Women Seeking Abortions in Akron, Ohio

Defendants and intervenors request that this Court review the decision of the Sixth Circuit invalidating the five ordinance sections listed supra. One of the reasons why this Court should deny the writ is that these sections were invalidated on the basis of an extensive factual presentation heard by the District Court and reviewed by the Court of Appeals.[7]

1. Section 1870.05 (B), requiring parental or judicial consent and mandatory parental notification in the case of every minor under fifteen was proven to be unduly burdensome.

Detailed testimony was provided with respect to the impact of Ordinance

7. Plaintiffs presented 28 witnesses and 54 exhibits. Defendants and intervenors presented 17 witnesses and 18 exhibits. The trial record is well over 2,000 pages in length.

Section 1870.05(B) which cedes parents or judicial officers an absolute veto whenever women under fifteen years of age seek abortions and which in conjunction with Ohio Revised Code Chapter 2151, requires parental notification in all such cases regardless of the women's best interest or maturity. As the District Court noted, the intervenors have specifically conceded that notification is required in all cases. Akron Center for Reproductive Health v. City ofAkron, 479 F. Supp. at 1202.

The evidence adduced at trial demonstrated that the "veto and notification" rule is burdensome for a variety of reasons. Its existence will impede a significant number of young

women from seeking pregnancy-related medical care and will thereby increase the health risk they face. (J.A. 196-201,276-283) Some young women will be forced to seek care outside Akron (J.A.104-105, 201, 279), exposing them to the increased risks associated with travel and diminished opportunities for follow-up care. (J.A. 98-99, 382) For those who seek abortions in Akron the "veto and notification" rule will increase the risk of physical assault by abusive parents (J.A. 280), increase the likelihood of psychological injury (Id.), increase the risk of suicide attempts (Id.) and exacerbate the risk of destructive family strife. (J.A. 102, 200, 211, 280) The evidence also demonstrated that early abortion is far safer for young women than forced childbirth. (J.A. 194-195, 209-210, 274-275, 332-333, 339-343).

This criminal statute does not address any current problem or need because the vast majority of teenagers under fifteen have voluntarily involved their parents in the abortion decision and are accompanied by a parent to the Akron clinics. (J.A.119, 140, 152-153, 179, 228, 263,314-315, 476, 480-484.) A four month survey at plaintiff Akron Center for Reproductive Health indicated that 26 of 29 women 14 years of age came to the clinic with a parent, while each of the seven younger women who came in was thus accompanied. (J.A. 152-153) The primary reason why Akron women under 15 years of age have not, on occasion, involved their parents in the abortion decision-making process was described by Yvonne Bolitho, Director of Counseling at plaintiff Akron Center for Reproductive Health, "their concern was that additional physical abuse would occur if

the parents were knowledgeable of the abortion." (Transcript Volume III at 73-74)

The evidence further demonstrated that some women under fifteen are mature and can make the requisite medical decision when necessary. This was the view of Dr. Felix Heald, Professor of Pediatrics and Director of the Division of Adolescent Medicine at the University of Maryland School of Medicine (J.A. 201), Dr. Adele Hofmann, Professor of Pediatrics and Director of the Adolescent Medical Unit of the New York University Medical Center (J.A. 284,303), and of defendants' expert Dr. Jasper Williams. ("[S]ome kids at 14 are more mature than their parents and you have more trouble talking to the parents than the patient. "(J.A. 747))

2. Section 1870.06(B) setting forth 44 lines of information the attending physician must recite to every woman, would substantially burden women

seeking abortions in Akron and their physicians.

Section 1870.06(B) of the Akron ordinance inflexibly mandates that the physician, on threat of criminal penalty, recite in every case the information outlined in 44 lines of printed material (Appendix 121a-122a) to pregnant patients seeking abortions. Included in this material is a requirement that the physician provide a detailed description of the "anatomical and physiological characteristics of the particular unborn child," and that he state "that the unborn child is a human life from the moment of conception." The District Court found that this Section of the ordinance requires the recital of information that may be untrue and information that is unavailable to medical science. 479 F. Supp. at 1203. The inflexibility of Section 1870.06(B)

is its clearest and most injurious defect. It can cause psychological harm to patients and destroy the informed consent dialogue.[8] (J.A. 353, 359, 367-368) The evidence demonstrated other flaws as well. As noted by the District Court, these include an insistence that physicians provide information unavailable to medical science[9] and

8. Plaintiffs' witness, Dr. Jay Katz, of the Yale Medical and Law Schools testified that in 11 to 17 percent of all cases of medical treatment patients do not wish to hear a detailed recitation of risks or procedures. (J.A. 352-353) In the interest of preserving the patient's health, well-being and ability to make a rational decision it is sometimes necessary for the physician to exercise therapeutic privilege and dispense with such recitations. (Id.) This is as important in the abortion context as elsewhere. (J.A. 362-363) The State of Ohio specifically recognizes therapeutic privilege in Ohio Sanitary Code Section 3701-47-06 which requires that in all abortions after the fourteenth week from the last menstrual period "counseling ... shall not be forced upon the woman."

9. See, e.g., the testimony of plaintiffs' witness, Nobel laureate, Dr. Frederick Robbins, that despite the demand of subsection 1870.06(B)(3), science has no answer to the question whether a fetus at six weeks gestation feels pain. (J.A. 406)

that they make potentially misleading, threatening or unscientific declarations.[10] Other flaws include the requirements that physicians provide information to their patients before accurate data can be obtained;[11] and, that they provide data without any clearly delineated limitations.[12] Any

10. See, e.g., the testimony of plaintiffs' witness Dr. Christopher Tietze, one of the foremost population demographics and birth control experts in the United States, that despite the assertion of subsection 1870.06(B)(5) there is no evidence that early abortion increases the risk of sterility or later miscarriage. (J.A. 381)

11. For the physician performing menstrual extractions it is impossible, because of the early stage of the pregnancy, to flatly declare to the patient whether or not she is pregnant as required by subsection 1870.06(B)(1). See Planned Parenthood of Kansas City v. Ashcroft, 655 F.2d 848, 868-69 (8th Cir., 1981).

12. As the District Court noted in this case, subsection 1870.06(B)(3) requires a limitless recitation of fetal characteristics, by using the phrase "including, but not limited to..." 479 F. Supp. at 1203. The same problem is posed by subsections 1870.06(B)(6) and (7) which require the provision of limitless lists of counseling agencies. (Appendix 122a)

deviation from the requirements of this section may be punished as a first degree misdemeanor.

3. Section 1870.06(C) requiring that the "attending physician" personally inform each patient is psychologically and economically burdensome in Akron, Ohio, where there are few doctors who perform abortions.

Using a "rational basis" test, the District Court upheld Section 1870.06(C), requiring that the "attending physician"[13] personally, in every case inform his patient "of the particular risks associated with her own pregnancy

13. Nowhere in Chapter 1870 is the word "attending" defined. However, both defendants and intervenors have at all times interpreted the word to mean the same doctor who is to perform the abortion. See, e.g., material cited in note 5, supra. This distinguishes Section 1870.06(C) from the regulation upheld in Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848 (8th Cir., 1981), where counseling had to be performed by a physician not "the" physician.

and the abortion technique to be employed." (Appendix 122A) In examining the same evidence, but using a stricter standard of review, the Court of Appeals concluded that this requirement directly interferes with the exercise of a woman's right to seek an abortion and is unconstitutional.

It was uncontested that the majority of women seeking abortions in Akron have been professionally counseled and have made up their minds with respect to the necessity for an abortion before they arrive at one of the Akron clinics.

(J.A. 140, 170, 225, 262-263, 314, 477, 512, 558, 735) Further the District Court specifically found that, except in cases of therapeutic concern, each patient is counseled at the Akron clinics, informed orally and in writing of the risks attendant to the abortion procedure, instructed in techniques of birth control, and provided aftercare instructions before an abortion is ever performed. 479 F. Supp. at 1181-1182.

The District Court also found that the attending physician at each procedure performed in one of the Akron clinics reviews each patient's medical chart with her (the charts contain information concerning counseling, medical history and desire for an abortion), makes inquiry concerning any questions the patient may have and performs a thorough pelvic examination. 479 F. Supp. at 1182. If the doctor at any time during

this process detects a note of hesitancy or ambivalence with respect to the abortion procedure he will "suggest that [the patient] return at another time after she [has] had some additional time to consider alternatives to abortion." 479 F. Supp. at 1182 (J.A.148-149, 175, 221, 515, 593, 609).

Section 1870.06(C) has the effect of overriding the physician's choice concerning counseling. It forces the attending physician to carry out all phases of pre-abortion counseling whether or not, in his professional judgment, he is the best one to perform the task.

Section 1870.06(c) also has the effect of substantially increasing the cost of abortions in Akron. (J.A. 222-224, 495, 516) When coupled with the twenty-four hour delay provision of the ordinance, Section 1870.06(C) may require that the same physician see each woman on

at least two occasions twenty-four hours apart[14] thereby multiplying operating expenses dramatically. (Id.) The burden imposed by Section 1870.06(C) is exacerbated by the fact that there are very few physicians who perform abortions in Akron, Ohio. The few physicians who do perform abortions have only been willing to devote a limited amount of their professional time to work in the clinics. (J.A. 116, 222-224, 458, 521) A substantial increase in the time required of each physician is likely to lead to the shutdown of the clinics or a substantial increase in their operating cost. (Id.)

14. The question of when the physician must speak the words mandated by Section 1870.06(C) is not free from doubt. This "vagueness" is an additional defect of the section and is discussed at note 5 supra.

4. The evidence overwhelmingly supports the circuit court's holding that Section 1870.07 mandating a twenty-four delay, burdens women seeking abortions in Akron, Ohio.

Section 1870.07 of the Akron ordinance imposes at least a twenty-four hour delay between the time a woman signs a mandatory consent form and the performance of the abortion procedure. Although the District Court found this burdened women needing abortions, it upheld the requirement under a rational basis test.[15] 479 F. Supp. at 1204-1205. The Sixth Circuit, consistent with the three other Circuits that have addressed this issue (see Point II, infra), reversed, holding that the requirement was neither supported by a compelling state interest, nor narrowly tailored. 651 F.2d at 1208.

15. The District Court found that delay will increase costs and will force each woman to make at least two trips to the clinic, with attendant travel, child care, and work loss expenses. 479 F. Supp at 1204-1205 (Appendix 98a).

The evidence demonstrated that twenty-four hours is the minimum delay caused by Section 1870.07. In most cases the delay will be for longer, because Akron clinics perform abortions only three days a week, and specialized procedures involving anesthesia only once a week. (J.A. 139, 156, 222-224, 226-228, 495, 521) Delays of from two to seven days will be the norm. (Id.) The evidence indicated that these delays will expose women seeking abortions in Akron to serious increases in morbidity and mortality risks (J.A. 107, 116, 305-306), and can also cause serious psychological harm. (J.A. 115-117, 368-369) Imposing an unwaivable delay on victims of rape was described by the witnesses as perhaps the most serious psychological problem, however delay will cause injury in other cases as well. (Id.)

REASONS WHY THE PETITION SHOULD NOT BE GRANTED

I. DEFENDANTS HAVE PREVIOUSLY CONCEDED THE UNCONSTITUTIONALITY OF ORDINANCE SECTIONS REGULATING MINORS AND IMPOSING VARIOUS RESTRICTIONS ON THE INFORMED CONSENT DIALOGUE

Despite the District Court ruling that Section 1870.05(B) (veto and notification) was unconstitutional, the defendants neither briefed nor argued the constitutionality of that section in the Sixth Circuit Court of Appeals. The Court of Appeals found that defendants had not appealed the ruling against them on this issue. 651 F.2d at 1205. Under these circumstances defendants have waived the right to argue the constitutionality of Section 1870.05(B) before this Court. See California v. Taylor, 353 U.S. 553, 556-557 n. 2 (1957).

Further, defendants in their brief to the Court of Appeals on February 28,

1980, specifically conceded that subsections (3), (4), and (5) of Section 1870.06(B) (mandating the recital of a 44 line script) were unconstitutional. Defendants requested that the Court of Appeals "sever the unconstitutional subsections [(3), (4) and (5)] of Section 1870.06(B)." Defendants' Brief to the Court of Appeals dated February 28, 1980 at 35. Defendants now attempt to retract this admission by arguing in their petition that all of Section 1870.06(B) is constitutional. Pursuant to California v. Taylor, this argument is improper and defendants are barred from urging the opposite of what they conceded in the court below.

II. THE DEFENDANTS AND INTERVENORS PRESENT NO SPECIAL AND IMPORTANT REASONS FOR THE GRANTING OF REVIEW

Rule 17 of this Court's Rules delineates "considerations governing review on certiorari." Defendants and

intervenors fail to make any reference to Rule 17, and in fact present no reason for the granting of review cognizable under Rule 17.

A. There Is No Conflict Between the Decision in the Present Case and Any Decision of Another Court of Appeals

Defendants and intervenors do not claim that certiorari should be granted because of a conflict between the ruling in the present case and the decision of another Circuit Court of Appeals. See Supreme Court Rule 17(a).In fact, the decision in this case is consistent with those in all the Circuits that have ruled on the issues.

In the past two years three Circuits besides the Sixth Circuit have reviewed statutes containing abortion restrictions almost identical to four of the five restrictions that defendants and intervenors are requesting this Court

review.[16] Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) (Charles); Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1981) (Planned Parenthood League); Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848 (8th Cir. 1981) (Ashcroft); see also Wynn v. Carey, 582 F.2d 1375 (7th Cir. 1978); 599 F.2d 193 (7th Cir., 1979); Womens Services, P.C. v. Thone, 636 F.2d 606 (8th Cir. 1980), reversed and remanded ____ U.S. ____, 69

16. Section 1870.16 ("humane" disposal) was held unconstitutional by both the District and Circuit Courts because its wording was "impermissibly vague" for a criminal statute. 479 F. Supp. at 1206; 651 F.2d at 1211. No other circuit has addressed this question although a textually similar Pennsylvania "enabling statute" was not held to be burdensome in Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (E.D. Pa. 1975), aff'd sub nom. Franklin v. Fitzpatrick, 428 U.S. 901 (1976). The distinctions between the present case and Fitzpatrick will be discussed at Point II C. infra.

L. Ed.2d 414 (1981). The Circuit Courts have agreed not only about the unconstitutionality of similar sections; they have also agreed on the constitutional standard of review to be used pursuant to the requirements of Roe v. Wade, 410 U.S. 113 (1973).

The standard of review used by the Circuits requires the court first to determine whether a state regulation directly interferes with the ability of the woman, with her doctor, to make or effectuate the abortion decision. If such interference is found, the state has the burden of justifying the regulation by showing a compelling interest. If a compelling state interest is established, the regulation must be further examined to determine whether it is sufficiently narrowly drawn so that it does not impose an "undue burden." See

Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1202-1204 (Akron Center); Charles, 627 F.2d at 776-778; Planned Parenthood League, 641 F.2d at 1014-1016; Ashcroft, 655 F.2d at 855.

Each of the four Circuits has concluded that a state-mandated waiting period is burdensome and supported by no compelling interest. See Akron Center, 651 F.2d at 1208; Charles, 627 F.2d at 785-786; Planned Parenthood League, 641 F.2d at 1014-1016; Ashcroft, 655 F.2d at 866. Each of the four Circuits has also invalidated as burdensome, state-mandated intrusions into the informed consent dialogue between the physician and pregnant patient. See Akron Center, 651 F.2d at 1206-1207; Charles, 627 F.2d at 779-784; Planned Parenthood League, 641 F.2d at 1016-1022; Ashcroft, 655 F.2d at

866-869. (The cases contain minor variations based primarily upon differences in the statutes under consideration or upon the vagaries of the factual showing made in each case.) Finally, three of the four Circuits have agreed with respect to the unconstitutionality of regulations which provide no alternative to mandatory parental notification or consent.[17] See Akron Center, 651 F.2d at 1205; Planned Parenthood League, 641 F.2d at 1009-1011; Ashcroft, 655 F.2d at 857-859. (In Akron Center and Ashcroft this led to invalidation. In Planned Parenthood League the statute provided an alternative and was upheld.)

17. The Seventh Circuit had previously invalidated a "veto and notification" requirement for minors in Wynn v. Carey, 582 F.2d 1375 (7th Cir. 1978).

B. The Decision of the Court of Appeals Is Consistent with the Decisions of This Court

1. The standard of review used by the Sixth Circuit is consistent with the standard of review of this Court

Defendants and intervenors distort the standard of review used by this Court in assessing abortion restrictions. They propose that the proper standard is that every abortion regulation should stand if the plaintiffs do not come forward and prove that the regulation "unduly burdens" a woman's right to choose abortion. This proposal would not only overturn the standard established in Roe v. Wade, but would also make judicial scrutiny in cases involving abortion restrictions radically different from

scrutiny in cases involving every other fundamental constitutional right.

This Court has consistently adhered to the position it first established in Roe v. Wade, that state interference which burdens the abortion decision is only permissible when the state has demonstrated a compelling interest justifying regulation. Roe v. Wade, 410 U.S. at 155, 162-163. This standard was affirmed in Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976), as well as the cases that have followed it. As this Court stated in Carey v. Population Services International, 431 U.S. 678 at 688 (1977), abortion regulations "'may be justified only by a compelling state interest ... and must be narrowly drawn to express only the legitimate state interests at stake.'"

Defendants place central reliance on Thone v. Womens Services P.C., ___ U.S.

___, 69 L.Ed.2d 414 (1981) an order vacating and remanding an Eighth Circuit decision. Defendants cite Thone no fewer than seven times in support of five of their seven arguments. Such reliance is misplaced because an order vacating and remanding a lower court decision is devoid of precedential authority. See Henry v. City of Rock Hill, 376 U.S. 776, 777 (1964).

Defendants also rely on Harris v. McRae, 448 U.S. 297 (1980), and Maher v. Roe, 432 U.S. 464 (1977). Again, defendants' reliance is misplaced. This Court specifically restated in Maher its adherence to the standards established in Roe v. Wade. See Maher v. Roe, 432 U.S. at 475. Maher distinguishes "between direct state interference with a protected activity and state encouragement of an alternative activity." Id. It applies a relaxed

constitutional test only in the latter situation. Id. at 476-477. Harris v. McRae, reaches precisely the same result. It declares that "if a law 'impinges upon a fundamental right ... [it] is presumptively unconstitutional'". Harris v. McRae, 448 U.S. at 312.

Finally, defendants seek to rely on decisions by this Court considering restrictions on the availability of abortions to minors. See Bellotti v. Baird, 428 U.S. 132 (1976) (Bellotti (I)); Bellotti v. Baird, 443 U.S. 622 (1979) (Bellotti (II)); and H.L. v. Matheson, 450 U.S. ___, 101 S. Ct. 1164 (1981). The requirements of these cases with respect to the law governing minors will be discussed at Point II B 2 infra. At this point, it should simply be noted that it is erroneous to use these cases as support for abortion regulations

governing adult women. In Planned Parenthood of Missouri v. Danforth, 428 U.S. at 74, this Court stated "the State has somewhat broader authority to regulate the activities of children than of adults." See Bellotti(II), 443 U.S. at 633-634; Carey v. Population Services International, 431 U.S. 678 (1977).[18]

2. The Court of Appeals' ruling is consistent with this Court's decisions concerning regulations restricting the availability of abortions to minors

The Court of Appeals in the present case invalidated Akron Ordinance Section 1870.05(B), which requires parental or

18. In Carey v. Population Services International, this Court held that restrictions on access to contraceptives by adults must be supported by a compelling state interest. 431 U.S. at 690. This Court further held, citing Planned Parenthood of Missouri v. Danforth, that, as to restrictions on minors, the test is "less rigorous than the 'compelling state interest' test applied...[to] adults," and significant state interests were sufficient. 431 U.S. at 693 fn. 15.

judicial consent and cedes to parents or judicial officers an absolute veto whenever women under fifteen years of age seek abortions. Neither in Chapter 1870 nor in Ohio Revised Code Chapter 2151 is there any provision allowing "best interests" or "mature" minors to get an abortion. Both the District Court, 479 F. Supp. at 1201, and the Court of Appeals, 651 F.2d at 1205, concurred in the finding that an absolute veto requirement is imposed pursuant to Section 1870.05(B).

In Planned Parenthood of Missouri v. Danforth, this Court held "that the State may not impose a blanket provision ... requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor during the first twelve weeks of pregnancy." 428 U.S. at 74. This proposition was

reiterated in Bellotti v. Baird (II), when eight Justices of this Court agreed that an absolute veto is impermissible. See 443 U.S. at 643 (Opinion of Powell, J.); 443 U.S. at 653-654 (Opinion of Stevens, J.). Akron Ordinance Section 1870.05(B) authorizes a blanket veto and was properly held unconstitutional. (Chapter 1870 was drafted long before this Court's decision in Bellotti v. Baird (II), and is not informed by the principles announced in that opinion.)

Further, Section 1870.05(B) is unconstitutional because there is no way any minor can bypass parental notification. Once a complaint has been filed in a juvenile court in Ohio, notice must be provided to the parents of the child involved in the proceeding. See Ohio Revised Code Chapter 2151. Intervenors specifically admitted this

fact during the pendency of this action and the District Court took special notice of their admission. 479 F. Supp. at 1201. In Bellotti v. Baird (II), Justice Powell, writing for four Justices of this Court, concluded that a blanket parental notice requirement is unconstitutional. See 443 U.S. at 642-648. In H. L. v. Matheson, at least five Justices of this Court concurred in the proposition that "a State may not validly require notice to parents in all cases." See 101 S.Ct. at 1176-77 (Concurring Opinion of Powell, J.); 101 S.Ct. 1184-1194 (Dissenting Opinion of Marshall, J.). Upon the strength of these precedents the Court of Appeals for the Eighth Circuit invalidated a blanket notication requirement in Ashcroft. See 655 F.2d at 859.

3. The Court of Appeals' ruling is consistent with this Court's rulings concerning regulations interfering with the abortion decision-making process

This Court has consistently stressed the importance of respect for the professional judgment of the physician in the abortion context. In Planned Parenthood of Missouri v. Danforth, this Court permitted the states to require that the woman give her "informed consent" before an abortion is performed. See 428 U.S. at 65-67. However, Danforth specifically limited "informed consent' by construing it to mean

> the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.

Id. at 67, n. 8. In Colautti v. Franklin, 439 U.S. 379, 387 (1979) this Court found that "up to the points where important state interests provide compelling justifications for intervention 'the abortion decision in all its aspects is inherently and primarily a medical decision.'"[19]

Chapter 1870 impermissibly straitjackets the physicians in the practice of their profession. First, the Chapter requires a written consent form of the sort authorized in Danforth.

19. Consistent with these principles is this Court's affirmance of the decision of the Eighth Circuit in Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978) aff'd 440 U.S. 941 (1979). There the Circuit Court invalidated a regulation compelling the physician to tell each woman that any live-born infant resulting from an attempted abortion would become the ward of the state. The Eighth Circuit condemned the regulation because it interjected "irrelevant and extraneous" material into the informed consent dialogue and jeopardized the physician-patient relationship. Freiman v. Ashcroft, 584 F.2d at 251-252.

(Section 1870.06(A)--not challenged here.) The Chapter goes on from there to establish an inflexible rule that the attending physician personally in all cases, recite a 44 line statement including inaccurate, biased, and irrelevant material including the statement that the "unborn child is a human life from the moment of conception." (Section 1870.06(B)) The ordinance next requires that in all cases, the "attending physician" separately recite (at some inadequately defined time) details about risk and procedure. (Section 1870.06(C)) Finally, the ordinance inflexibly mandates that all abortions be delayed at least twenty-four hours. (Section 1870.07) Any deviation from this procedure exposes the physician to criminal liability, including a jail sentence and possible loss of license.

Not only are these restrictions a straitjacketing of the physician, they are also fundamentally incompatible with the doctrine of informed consent which seeks to preserve the physical and psychological integrity of the patient by allowing her (rather than the state) a significant degree of control over the treatment process.[20]

20. For a discussion of the doctrine of informed consent see J. Katz, EXPERIMENTATION WITH HUMAN BEINGS, 540-588 (1972). Pursuant to the doctrine of informed consent there are two situations in which information should not be pressed upon a patient. The first of these involves the patient's specific request not to be informed. See Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1 (1972); Ohio Sanitary Code Section 3701-47-06 (referring specifically to second trimester abortions). The second arises when the physician specifically determines that the recital of information will be harmful and exercises a therapeutic privilege not to provide it. See Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

C. A Number of the Questions Presented by Defendants Are of No General Importance

Defendants complain about the failure of the District Court and the Court of Appeals to redraft various sections of Chapter 1870 (Sections 1870.06(B) and 1870.16) by severing allegedly constitutional fragments from unconstitutional material. Determinations about severability made by district courts will not be upset without a showing of good reason therefore. See Sloan v. Lemon, 413 U.S. 825, 834 (1973).

In the present case both the District Court and the Court of Appeals passed upon the question of severability. Each determined that judicial redrafting of the arguably constitutional bits and pieces of invalid sections of Chapter 1870 was inappropriate. In similar circumstances the Sixth Circuit has previously held it inappropriate for a court to "untangle the constitutional provisions from the unconstitutional ... by attempting to rewrite the minor provisions of the ordinance." Mahoning Women's Center v. Hunter, 610 F.2d 456, 460-461 (6th Cir. 1979), vacated and remanded on other grounds, 447 U.S. 918 (1980). Defendants have not satisfied the requirements of Sloan v. Lemon, nor have they demonstrated that the sections could have or should have been untangled and rewritten. Finally, the question whether minor fragments of the ordinance

should have been judicially redrafted can hardly be said to be of any general significance, and is, therefore, not a subject fit for review. See Magnum Import Co.v. Coty, 262 U.S. 159, 163 (1923).

Defendants appear to claim that the question of the vagueness of the word "humane" as used in Section 1870.16 (a criminal ordinance) is a fit question for the plenary consideration of this Court. Both the District Court and the Court of Appeals have rejected defendants' arguments. Further, this Court's ruling in Colautti v. Franklin, applies because the word "humane" is, in this context, "little more than a trap for those who act in good faith." 439 U.S. at 395. Defendants' only argument is that the present decision is inconsistent with that in Planned Parenthood v. Fitzpatrick, 401 F. Supp. 554 (E.D. Pa.

1975) aff'd sub nom. Franklin v. Fitzpatrick, 428 U.S. 901 (1976). This assertion is erroneous. Fitzpatrick reviewed nothing more than an "enabling statute" pursuant to which regulations had not as yet been adopted. 401 F. Supp. at 572-573. As indicated in Winters v. New York, 333 U.S. 507 (1947), enabling statutes are to be judged by a different standard than statutes directly regulating conduct. Further, as with the question of severability, it can hardly be said that the question defendants present is so important as to warrant this Court's review. See Magnum Co. Import v. Coty, 262 U.S. at 163.

III. REVERSAL OF THE DECISION OF THE COURT OF APPEALS WOULD LEAD TO CONFUSION IN THE DETERMINATION OF CASES INVOLVING ABORTION REGULATION AND WOULD PROMOTE AD HOC ADJUDICATION

There is remarkable agreement within the Circuits concerning regulations

restricting access to abortions. The clarity of the principles upon which decisions are now being rendered has produced this high degree of decisional uniformity. The announcement of a new and different set of standards by this Court could serve to introduce uncertainty where none now exists.

The greatest source of uncertainty would be the sort of "standardless" due process test advocated by the defendants and intervenors. Adoption of such a test would mean nothing more nor less than unstructured district court review premised upon an ad hoc search for "reasonableness" in each case. See Charles v. Carey, 627 F.2d at 778. The variety of results and conflicts that would arise would be extensive. In a different area this Court has declared that such ad hoc adjudication "would lead to unpredictable results and uncertain

expectations and it could render our duty to supervise the lower courts unmanageable." Gertz v. Robert Welch, Inc., 418 U.S. 323, 343 (1974).

IV. THE LAPSE OF TIME HAS RENDERED INTERVENORS' CLAIMS MOOT

At trial intervenor Seguin testified that he had a fourteen year old daughter and another daughter of unspecified age. (Transcript Volume VII at 49) Intervenor Black testified that she had a fourteen year old daughter. (J.A. 499) Each of the described daughters is now at least seventeen years of age. Neither intervenor provided any information on the record about any other daughters. The focus of intervenors' Petition is Section 1870.05(B) of the Akron Ordinance which applies only to "minor pregnant [women] under the age of fifteen (15) years." It would appear, based on the record in this case, that the lapse of

time has rendered intervenors' claims moot.

In Atherton Mills v. Johnston, 259 U.S. 13 (1922), both a parent and a child filed suit to challenge the constitutionality of the Child Labor Tax Act which placed limits on the hours worked by a child under sixteen years of age. During the pendency of the litigation the child passed his sixteenth birthday. This Court, per Chief Justice Taft, held that the "lapse of time" had rendered the case moot. Atherton Mills v. Johnston, 259 U.S. at 15. The Court so held with respect to the independent action of the parent as well as the action of the minor.

Where, as here, no class has been certified and a litigant has no continuing interest in the action, his claims must be dismissed as moot. See Atherton Mills v. Johnston; Indianapolis

School Commissioners v. Jacobs, 420 U.S. 128 (1975); DeFunis v. Odegaard, 416 U.S. 312 (1974). The major exception to this rule involves cases that are "capable of repetition yet evading review." In Weinstein v. Bradford, 423 U.S. 147 (1975), this Court defined such cases as those in which it is "virtually impossible" to litigate in the time before the occurrence of the mooting event and in which the same party faces the identical problem in the future. Id. at 149. Here, intervenors have satisfied neither part of the Weinstein test. Any number of parents might be found who could establish on the record a continuing interest stretching over many years. Intervenors have not established such an interest. Under these circumstances intervenors claims should be dismissed as moot.

As a final matter it should be noted that intervenors were allowed to proceed in this case only for the purpose of advancing claims touching on Section 1870.05 of the Akron Ordinance and perhaps those subsections of 1870.06 brought into play because of Section 1870.05.[21] Pursuant to this Court's ruling in Boston Tow Boat v. United States, 321 U.S. 632 (1944), intervenors may only appeal those questions directly arising out of an "appealable interest." Here intervenors' interest has been rendered moot and no appeal is appropriate.

21. See note 4 supra.

CONCLUSION

For the foregoing reasons the petitions for a writ of certiorari should be denied.

Dated: Cleveland, Ohio
December, 1981

Respectfully submitted,

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328

GORDON BEGGS
American Civil Liberties Union
of Cleveland Foundation, Inc.
1223 West Sixth Street
Cleveland, Ohio 44113
(216) 781-6276

JANET BENSHOOF
American Civil Liberties Union
Foundation
132 West 43rd Street
New York, N.Y. 10036
(212) 944-9800

Attorneys for Respondents

Office - Supreme Court, U.S.
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Nos. 81-746 and 81-117[illegible]

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AND

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners

v.

CITY OF AKRON, *ET AL.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR PETITIONER CITY OF AKRON

ROBERT D. PRITT
Director of Law
The City of Akron
166 South High Street
Akron, OH 44308-1655
(216) 375-2031
Attorney for Petitioner

Washington, D.C. • THIEL PRESS • (202) 628-4821

QUESTIONS PRESENTED

1. Whether the state's interest in maternal health and wellbeing is such that it may regulate abortion in a reasonable manner which is not unduly burdensome, even during the first trimester of pregnancy.

2. Whether a child under the age of fifteen years can be required to obtain the consent of one parent or her legal guardian or a court order authorizing the minor to consent to an abortion.

3. Whether the state can require the physician personally to inform the woman of facts relating to her pregnancy, the abortion procedure, fetal development, and agencies available to assist her.

4. Whether the state can require the physician personally to counsel the patient with respect to the risks and technique of the abortion prior to performing the abortion.

5. Whether the state can require a waiting period of twenty-four hours between the signing of an informed-consent form and the performance of an abortion.

6. Whether the term "humane" as it relates to the disposal of fetuses in Section 1870.16 is void for vagueness, and if so, whether the term is severable from the balance of the section in accordance with City Council's express intent that the provision be severable.

PARTIES

Petitioner, the City of Akron, was Defendant below along with John Ballard, Mayor; Dr. C. William Keck, Director of Public Health; and Peter Oldham, Prosecutor. Co-Defendants in the trial court were Dr. Francois Seguin and Mrs. Kathleen Black who were permitted to intervene "in their individual capacity as parents of unmarried daughters of child-bearing age" and who were permitted to appear as amici curiae on all issues in the case. The Respondents in this litigation are Akron Center for Reproductive Health, Inc.; Akron Women's Clinic, Inc.; Womencare, Inc.; and Dr. Bliss, a physician who had worked in one of the abortion clinics and who claimed to represent the rights of clinic patients who desired abortions.

TABLE OF CONTENTS

	PAGE
Questions Presented	i
Parties	ii
Table of Contents	iii
Table of Authorities	v
Opinions Below	vii
Jurisdiction	vii
Statutory Provisions	viii
Statement of Case	1
A. Procedural Overview	1
B. Statement of Facts	3
Summary of Argument	13
Argument	18
I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS.	18
II. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE	

PAGE

MINOR'S HEALTH BY REQUIRING PARENTAL OR JUDICIAL CONSENT TO AN IMMATURE, UNEMANCIPATED MINOR'S ABORTION. 24

III. THE STATE HAS A LEGITIMATE INTEREST IN INSURING INFORMED CONSENT. 32

IV. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING PHYSICIAN-PATIENT COUNSELING PRIOR TO THE ABORTION. 37

V. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING A TWENTY-FOUR HOUR WAITING PERIOD. 43

VI. THE TERM "HUMANE" AS USED IN SECTION 1870.16 IS NOT UNCONSTITUTIONALLY VAGUE. 47

Conclusion 50

TABLE OF AUTHORITIES

	PAGE
Akron v. Scalera, 135 Ohio State 65, 19 N.E. 2d 279 (1939)	27
Ashwander v. Tennessee Valley Authority, 297 U.S. 288 (1936)	29
Bellotti v. Baird, 428 U.S. 132 (1976)	15, 21, 28, 29, 30, 31, 43, 44
Bellotti v. Baird, 443 U.S. 622 (1979)	6, 15, 23, 25, 26, 30, 32, 40
Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932)	49
Colautti v. Franklin, 439 U.S. 379 (1979)	19, 40
Connecticut v. Menillo, 423 U.S. 9 (1975)	23, 39
Doe v. Bolton, 410 U.S. 179 (1973)	3
Franklin v. Fitzpatrick, 428 U.S. 901 (1976)	36, 48
Globe Newspapers v. Superior Court, ____ U.S. ____ (1982)	15, 32
Griswold v. Connecticut, 381 U.S. 479 (1965)	39
Harris v. McRae, 448 U.S. 297 (1980)	44
Harrison v. NAACP, 360 U.S. 167 (1959)	29
H.L. v. Matheson, 450 U.S. 398 (1981)	15, 22, 23, 28 29, 30, 35, 43, 44, 45

TABLE OF AUTHORITIES (CONTINUED)

	PAGE
Kleppe v. New Mexico, 426 U.S. 529 (1976)	29
Lies v. Cleveland Ry. Co., 101 Ohio State 162, 128 N.E. 73 (1920)	27
Maher v. Roe, 432 U.S. 464 (1977)	21, 33, 40, 44
New York v. Ferber, _____ U.S. _____ (1982)	15, 29, 31
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)	9, 10, 19, 20, 21, 23, 25, 31, 40, 43, 44, 46
Planned Parenthood Assn. v. Fitzpatrick, 401 S. Supp. 554 (1975), aff'd Franklin v. Fitzpatrick, 428 U.S. 901 (1976)	36, 41, 48, 49
Rodos v. Michaelson, 396 F. Supp. 768, rev'd on other grounds, 527 F. 2d 582 (1st Cir. 1975)	46
Roe v. Wade, 410 U.S. 113 (1973)	3, 9, 15, 16, 19, 21, 35, 37, 38, 39, 40
Thone v. Womans Services, P.C., _____ U.S. _____, 69 L. Ed. 2d 414 (1981)	22, 23, 29, 30, 45
Whalen v. Roe, 429 U.S. 589 (1977)	21
Wolfe v. Schroering, 541 F. 2d 253 (6th Cir. 1976)	46, 47
Wynn v. Scott, 449 F. Supp. 1302 (N.D. Ill. 1978)	36

STATUTORY PROVISIONS

The pertinent parts of the United States Constitution, Amendment XIV, Section 1; the Ohio Constitution, Art. XVIII, Section 3; and 3 Ohio Administrative Code, 3701-4705, are reprinted in the petition for certiorari (IX). The pertinent parts of Ohio Revised Code Chapter 2151 are reprinted in the separate appendix to the petition in No. 81-746 as App. I (130a-145a). The pertinent parts of the Ohio Rules of Juvenile Procedure are reprinted in the appendix as App. J (146a-150a). Akron Ordinance No. 160-1978 is reprinted in its entirety in the appendix as App. H (115a-129a).

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit, rendered on June 12, 1981, is reported as Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F. 2d 1198 (6th Cir. 1981), and is reprinted in the separate appendix to the petition in No. 81-746 as App. A (1a-36a). The opinion of the United States District Court for the Northern District of Ohio, Eastern Division, rendered on August 22, 1979, is reported as Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979), and is reprinted as App. E (43a-106a).

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was entered on June 12, 1981. A petition for rehearing was filed with the Court of Appeals by the Petitioners, the Respondents, and the Defendant-Intervenors. The Court of Appeals denied all parties' petitions for rehearing. The Defendant-Intervenors' petition for rehearing was denied on July 22, 1981. This petition for certiorari was filed within ninety (90) days of that date on October 13, 1981. This Court's jurisdiction is invoked under 28 U.S.C. Section 1254(1).

STATEMENT OF THE CASE

A. Procedural Overview

Ordinance No. 160-1978 (App. 115a) was enacted by the Akron, Ohio, City Council on February 28, 1978, in order to regulate the provision of abortions within the City of Akron and thereby provide its citizens with a high standard of health care. The ordinance amended and supplemented Chapter 1870, entitled "Regulation of Abortions" of the Codified Ordinances of the City of Akron, and was to have become effective on May 1, 1978.

Respondents instituted an action challenging the facial validity of Ordinance No. 160-1978 on April 19, 1978. A preliminary injunction restraining enforcement of the ordinance was entered on April 27, 1978 by the United States District Court for the Northern District of Ohio, the Honorable Leroy J. Contie, Jr., presiding. A trial on the merits was held September 5-21, 1978. The final decision on the merits was rendered on August 22, 1979 (App. 43a), holding Sections 1870.05, 1870.06(B), 1870.09 and 1870.16 of the ordinance unconstitutional and permanently enjoining the enforcement of those provisions. (App. 106a). The District Court further held that the respondents lacked standing to challenge Sections 1870.02, 1870.03, 1870.04, 1870.11, 1870.12, 1870.13, 1870.14 and 1870.15 of Ordinance No.

160-1978. (App. 106a). The remaining sections of the ordinance were held to be constitutional. (App. 106a). Upon the filing of a motion to alter or amend the judgment pursuant to F.R. Civ. P. 59, the original Memorandum, Opinion and Order were modified by the Order of the District Court filed on October 4, 1979. (App. 107a).

Timely appeals were filed by all parties in the United States Court of Appeals for the Sixth Circuit. The Court of Appeals, on June 12, 1981, affirmed in part and reversed in part the judgment of the District Court. (App. 1a). Sections 1870.05(B), 1870.06(B), 1870.06(C), 1870.07 and 1870.16 were held unconstitutional by the majority of the Court (App. 1a). Judge Cornelia Kennedy filed a concurring and dissenting opinion on the merits (App. 25a). Motions for rehearing filed by the parties were denied on July 10 and 22, 1981. (App. 39a, 41a).

Petitioner, City of Akron, was granted certiorari on the following issues which have remained unresolved by this Court:

1. Whether the state's interest in maternal health and wellbeing is such that it may regulate abortion in a reasonable manner which is not unduly burdensome, even during the first trimester of pregnancy.

2. Whether a child under the age of fifteen years can be required to obtain the consent of one parent or her legal guardian or a court order authorizing the minor to consent to an abortion.

3. Whether the state can require the physician personally to inform the woman of facts relating to her pregnancy, the abortion procedure, fetal development, and agencies available to assist her.

4. Whether the state can require the physician personally to counsel the patient with respect to the risks and technique of the abortion prior to performing the abortion.

5. Whether the state can require a waiting period of twenty-four hours between the signing of an informed-consent form and the performance of an abortion.

6. Whether the term "humane" as it relates to the disposal of fetuses in Section 1870.16 is void for vagueness, and if so, whether the term is severable from the balance of the section in accordance with City Council's express intent that the provision be severable.

Respondents were also granted certiorari in Akron Center for Reproductive Health, Inc. v. City of Akron, Case No. 81-1172, on the following questions:

1. Whether the Sixth Circuit Court of Appeals correctly denied petitioners therein standing to challenge Section 1870.03 of the Akron Ordinance; and

2. Whether this Court should reconsider its holdings in Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) that a state's interest in maternal health is "compelling" at the end of the first trimester of pregnancy.

B. Statement of the Facts

In order to promote the health and safety of

women seeking abortions, the City Council enacted Ordinance No. 160-1978 which sets forth a number of requirements relating to the performance of abortions. Section 1870.05(B)[1] is the first section here in controversy and provides that in order for a girl under the age of 15 years to obtain an abortion she must have the consent of one of her parents or her legal guardian, or, in the alternative, a court may provide consent where the parent or guardian is unavailable or refuses consent. State law provides the procedure to be followed in such a judicial proceeding.[2] The state law to be applied was unchallenged in these proceedings and consequently

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[1]Section 1870.05(B): "No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen (15) years without first having obtained the informed written consent of the minor pregnant woman in accordance with Section 1870.06 of this Chapter, and (1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or (2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

[2]Chapter 2151 of the Ohio Revised Code sets forth the applicable procedure to be followed in all cases where a minor is seeking or in need of judicial consent to a medical procedure. (App. 130a).

the District Court made no findings as to its operation and effect. Further, it is not to be assumed that the state court will not construe the ordinance in a manner consistent with the constitutional requirement of a determination of the minor's ability to make an informed consent. It is important to note that each of the experts who testified at trial conceded that it was most unlikely that a minor under the age of 15 could make an adequate decision on her own regarding pregnancy. (see e.g., Tr. X, 14).

The testimony at trial demonstrates that physicians have very little contact with pregnant minors who seek abortions at the respondent clinics. Ms. Francene Lucas, a counsellor at the Womancare Clinic, stated that in her understanding: "[i] t is not anybody's responsibility there at the clinic to judge the maturity of an under fifteen year old" (Tr. VII, 166), even though most of the patients visiting the clinic have visited it only on the day of the abortion (Tr. VII, 168), and even though maturity is conceded to be necessary for a truly informed consent. (Tr. II, 77, 83). Ms. Lucas felt that it was a "fair statement" to say that her role in counseling a minor was that of "information giving only." (Tr. VII, 174).

Both the District Court and the Court of

Appeals held Section 1870.05(B) unconstitutional. The Court of Appeals reasoned that Bellotti v. Baird, (Bellotti II), 443 U.S. 662 (1979), required invalidation of any statute which "provide(s) a possible third party veto" (App. 12a). The court, however, did not inquire into whether the judicial alternative was a sufficient alternative procedure whereby authorization for the abortion can be obtained under Bellotti (II). The District Court struck down Section 1870.05(B) even though the state juvenile court process as set forth in Chapter 2151 of the Ohio Revised Code was unchallenged in this case.

Section 1870.06(B)[3] provides that an attending physician must inform a woman prior to an abortion of several factors. This requirement is designed to

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[3]Section 1870.06(B): "In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows: (1) That according to the best judgment of her attending physician she is pregnant. (2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and

protect the physician-patient relationship and ensure that a woman's consent is truly informed.

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[3](continued) physical examination and appropriate laboratory tests. (3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members. (4) That her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion. (5) That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances. (6) That numerous public and private agencies and services are available to provide her with birth control information, and that her physician will provide her with a list of such agencies and the services available if she so requests. (7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

Counseling at the respondent abortion clinics is typically not performed by the attending physician or any medically trained personnel. Respondent, Dr. Bliss, testified that on those occasions when he had performed an abortion in Akron, he spent only five to ten minutes with each patient immediately prior to performing her abortion. (Tr. I, 180). This practice was admitted by Dr. Bowen, of the Summit County Medical Society, not to be in accord with his own standards, (Tr. II, 61-63) and he further stated that he had never looked into the counseling and procedures at the abortion clinics before rendering an opinion on the need for this ordinance. (Tr. II, 43-57). The District Court found that:

> A patient's contact with the physician who is to perform the abortion procedure usually occurs when she is taken into the operating room. At that time, the physician reviews the patient's medical chart and asks the patient if she has any questions. The doctor then performs a pelvic examination. If the pelvic examination does not reveal any medical problems and, further, indicates that the pregnancy has not progressed beyond the first trimester, the abortion usually will then be performed. (App. 46a-47a).

The Court of Appeals held all subsections of Section 1870.06 unconstitutional, regardless of their content, on the ground that they impose "restrictions

or regulations governing the pregnant woman's attending physician with respect to the termination of her pregnancy, [Planned Parenthood of Central Missiouri v. Danforth], 428 U.S. at 80, notwithstanding any showing whatsoever that a true doctor patient relationship of the sort contemplated in Roe, supra, even exists between the clinics and their patients.

The District Court made no findings of fact regarding the subsections involved. It held Section 1870.06(B) to be unconstitutional based upon its ruling that the state cannot "specify what each patient must be told." (App. 96a). The District Court did, however, state that it had "no doubt that the state could constitutionally require that all abortion patients be counseled, either by their attending physicians or another individual having specified minimum qualifications (footnote omitted)." (App. 96a).

Section 1870.06(C)[4] requires that the attending

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[4]Section 1870.06(C): "At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall, at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment

physician provide certain information to the woman regarding the risks associated with her pregnancy and the abortion technique to be employed as well as a general description of the medical instructions to be followed subsequent to the abortion. In addition, any other information which in the physician's judgment is relevant to her decision to have an abortion or carry the pregnancy to term may be given. The testimony at trial by physicians working for local abortion clinics established
that the physicians themselves neither personally consult nor counsel patients prior to an abortion. (Tr. VII, 7). Rather, nonphysician counselors provide such services to a women prior to her abortion. Several physicians testified at trial that proper medical practice required that a physician counsel the woman. (Tr. II, 64; VIII, 31; X, 25-26). While the Court of Appeals struck down Section 1870.06 in its entirety as imposing "restrictions or regulations governing the pregnant woman's attending physician with respect to the termination of her pregnancy, [Planned Parenthood of Central Missouri v. Danforth], 428 U.S. at 80," the District Court held Section 1870.06(C) constitutional. The District Court stated:

> Subsection (C)'s requirement that this information be imparted by the attending physician rather than by a counselor, as is

[4](continued) is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

presently done at the clinics operated by the corporate plaintiffs, however, makes effectuation of the abortion decision more expensive. That impact is not so great as to require a compelling state interest to support the requirement that the 'counseling' be done by the physician rather than by another individual. Akron's City Council could well have rationally concluded that because of the special relationship between a patient and her physician, such 'counseling' should be done by the physician. In so doing, it would further a valid state interest in the health of its female citizens.

Section 1870.07[5] of the Akron ordinance requires that there be a twenty-four hour delay between the time a women signs the consent form required by Section 1870.06 and the abortion procedure. This section is modified by Section 1870.12[6] which waives the twenty-

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[5]"1870.07 WAITING PERIOD

"No physician shall perform or induce an abortion upon a pregnant woman until twenty-four (24) hours have elapsed from the time the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have signed the consent form required by Section 1870.06 of this Chapter, and the physician so certifies in writing that such time has elapsed."

[6]"1870.12 EMERGENCY.

"The following provisions of this Chapter shall not apply where there is an emergency need for an abortion to be performed or induced such that continuation of the

four hour delay in the case of a medical emergency which poses an immediate threat and grave risk to the life or physical health of the pregnant woman.

There was substantial testimony at trial that a twenty-four hour waiting period between the signing of an informed consent and the abortion procedure would result in no disfavorable impact upon the woman. Respondents' medical expert, Dr. Crist, testified that the waiting period would not create a significant risk to the patient's physical health. (Tr. I, 82, 94 and 118). Respondents' witness, Dr. Bowen, who inspected the clinics as a member of the Summit County Medical Society and the Maternal Infant Health Committee, testified that it is preferable and better medical practice to separate counseling and the abortion procedure by twenty-four hours or more. (Tr. II, 65). Respondents' expert, Dr. Hoffman, testified that a twenty-four hour waiting period is desirable in most instances and that a twenty-four hour delay is not critical. (Tr. III, 147 and 168). Petitioners' experts, Dr. Sim and Dr. Schmidt, President of the

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[6](continued) pregnancy poses an immediate threat and grave risk to the life or physical health of the pregnant woman, and the attending physician so certifies in writing: (A) Section 1870.05. (B) Section 1870.06(B) with respect to the signature of one of the parents or the legal guardian of the pregnant woman where applicable. (C) Section 1870.07. (D) Section 1870.13. (E) Section 1870.14(B) with respect to aftercare of an abortion patient."

American College of Obstetrics and Gynecology, testified that the twenty-four hour waiting period is not significant in terms of risk and is desirable in terms of time to reflect. (Tr. VIII, 42; X, 12 and 26).

Based upon the testimony, the District Court found that this regulation did not unduly burden the woman's decision to have an abortion and that it furthered the important state interest of insuring "that a woman's abortion decision is made after careful consideration of all the facts applicable to her situation." (App. 99a).

The Court of Appeals reversed the District Court and held Section 1870.07 unconstitutional stating that "since Section 1870.07 causes a legally significant impact or consequence on the abortion decision, it cannot be applied to first-trimester abortions." (App. 17a).

Section 1870.16,[7] which requires that remains of the unborn child be disposed of in a humane and sanitary manner, was held unconstitutional by both courts below. This was based upon a finding by the District Court that the word "humane" was void for vagueness. (App. 103a).

SUMMARY OF ARGUMENT

Not all regulation of first-trimester abortions

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[7] "1870.16 DISPOSAL OF REMAINS

"Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a humane and sanitary manner."

impermissibly interferes with a woman's protected decision to have an abortion. Nor must the questioned regulation always serve a compelling state interest in order to be constitutional. The initial question posed on review before this Court is whether the state's interest in maternal health and wellbeing is such that it may regulate abortion in a reasonable manner which is not unduly burdensome, even during the first trimester of pregnancy.

The Court of Appeals, in prohibiting all direct regulation of first trimester abortions, incorrectly interpreted the standard of review to be applied in reviewing the constitutionality of abortion regulations. In applying a two-tier analysis to the Akron abortion ordinance, the Court of Appeals effectively held all first trimester regulation to be impermissible.

Initially, the Appellate Court looked to "the nature of the particular regulatory provision," inquiring as to whether or not the regulation had a "'legally significant impact or consequence' on the right of a pregnant woman, in consultation with a physician, to choose to terminate her pregnancy." Accordingly, if there was no legally significant impact or consequence, no constitutional issue was raised. Where the regulation resulted in a legally significant impact or consequence, the Court further required that the "regulatory provision serve a legitimate and compelling state interest." But, only if a compelling state interest was found would it further inquire as to

whether the regulation imposed an "undue burden" on the abortion decision. (App. 9a).

Decisions of this Court, subsequent to Roe, supra, clearly show that states have the right to regulate abortions performed during the first three months of pregnancy so long as such regulation does not "unduly burden" a woman's constitutionally-protected right to have an abortion.

In looking to the constitutionality of requiring an unemancipated and immature child under the age of fifteen years to obtain the consent of one parent or her legal guardian or a court order authorizing the minor to consent to an abortion; it is important to note that the Akron ordinance provides an "alternative procedure" whereby authorization can be obtained in accordance with the constitutional requirements enunciated by this Court in Bellotti II, supra. Additionally, it is important to note that this section is directed toward minors "as to whom there are unquestionably greater risks of inability to give an informed consent." H. L. V. Matheson, 450 U.S. 398, (1981); Bellotti v. Baird, Bellotti I, 428 U.S. 132 (1976). This Court recently held in New York v. Ferber, _____ U.S. _____, _____ (1982); that "it is evident beyond the need for elaboration that a state's interest in 'safeguarding the physical and psychological wellbeing of a minor' is 'compelling'. Globe Newspapers v. Superior Court, _____ U.S. _____, _____ (1982)."

In reviewing the constitutionality of a state regulation which requires the physician personally to inform the woman of facts relating to her pregnancy, the abortion procedure, fetal development, and agencies available to assist her, the courts below should have looked to see whether the regulation unduly burdened the woman's right, in consultation with her physician, to decide to terminate her pregnancy. Roe, supra. The requirement is designed to protect the woman by insuring that her consent will be truly informed and that it is given only after she has consulted with her physician. Such a provision strikes a reasonable balance between the woman's protected right and the state's interest in maternal health without unduly burdening her right to decide to terminate her pregnancy.

After evaluating Section 1870.06(C) of the Akron ordinance, the District Court held that this section did not unduly burden a woman's right to seek an abortion. (App. 97a). The Court of Appeals reversed the District Court and held that this section had a legally significant impact on a first-trimester abortion decision and was therefore invalid. (App. 17a). In so holding, the Court of Appeals did not apply the proper standard of review. Section 1870.06(C) does not impermissibly interfere with the physician-patient relationship fundamental to the right to decide to have an abortion. Rather, it furthers a valid state interest in the health of its citizens and

assures that the woman's consent will be truly informed.

The imposition of a twenty-four hour waiting period between the time a woman signs the informed-consent form and the abortion procedure in Section 1870.07 was found by the District Court not to unduly burden the woman's decision to have an abortion. (App. 99a). Once again, the Court of Appeals reversed stating that "since Section 1870.07 causes a legally significant impact or consequence on the abortion decision, it cannot be applied to first-trimester abortions." (App. 17a). Thus, this section was invalidated only because it impacted on decisions to have an abortion during the first three months of pregnancy. The proper standard of review requires that in considering the regulation the focus be placed on the burden imposed on the woman's decision to have an abortion.

Section 1870.16 of the Akron ordinance is the last section herein under review and requires that the remains be disposed of in a "humane and sanitary manner." At issue in this section is whether the term "humane" as it relates to the disposal of fetuses is void for vagueness, and if so, whether the term is severable from the balance of the section in accordance with the express legislative intent that the provision be severable.

In determining the constitutionality of an abortion regulation, this Court has consistently required only that the regulation not be unduly burdensome. When viewed in

this light, the sections of the Akron ordinance under review are clearly constitutional as they do not unduly burden the woman's right to seek an abortion. The Court of Appeals' two-tier analysis conflicts with the standard of review thus far enunciated by this Court in that it prohibits all direct regulation of first-trimester abortions on the basis of there being no compelling interest per se during the first trimester. Such a standard is clearly in error. Therefore, the appropriate disposition of this case is to reverse the decision of the Court of Appeals as to Sections 1870.06(C) and 1870.07, and remand for an affirmance of the decision of the District Court as to those sections. As to Sections 1870.05(B), 1870.06(B), and 1870.16 the decision of the Court of Appeals should be reversed.

I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS.

A. The Appellate Court failed to determine whether the regulation was "unduly burdensome."

In dissenting from the majority's opinion, Judge Kennedy stated:

> . . . the Supreme Court has never suggested the analysis put forth by the majority. It has sometimes suggested that a compelling state interest is necessary to justify any state regulation

> of abortion during the first trimester, but that language has always been far broader than required by the facts before it. With the exception of the passage in Colautti [v. Franklin, 439 U.S. 379 (1979)], and a part of Planned Parenthood, all of the cases since Roe have suggested that the proper standard is simply whether a regulation that does not effectively prohibit abortions is "unduly burdensome" to the decision whether or not to abort. The Court's decisions are all consistent with that standard. (App. 32a).

Following this Court's decision in Roe, supra, in which it was stated that the "state's important and legitimate interest in the health of the mother" became compelling at the end of the first trimester of pregnancy, both State and District Courts have periodically held any regulation of first-trimester abortions to be impermissible.[8]

Subsequent to Roe, however, this Court has made clear that the states have the right to regulate abortions performed during the first three months of pregnancy so long as such regulation does not "unduly burden" a woman's constitutionally-protected right to have an abortion.

The regulation of a first-trimester abortion was

[8]As shown by the Court of Appeals' holding that "if a regulation resulted in a legally significant impact or consequence on a first-trimester abortion decision, it is invalid." (App. 9a).

first permitted in Danforth, supra, wherein this Court upheld a state statute requiring the informed written consent of a woman, in the first trimester of pregnancy, and requiring certain recordkeeping and reporting by those providing the abortion. In its discussion, this Court noted that:

> [T]he state may not restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy . . . [However] the imposition by §3(2) of such a requirement (prior written consent) for termination of pregnancy even during the first stage, in our view, is not in itself an unconstitutional requirement. (Emphasis added.) 428 U.S. at 66-7.

Thus not all regulation of first-trimester abortions impermissibly interferes with a woman's protected decision to have an abortion, and the questioned regulation need not always serve a compelling state interest in order to be constitutional. This is shown by this Court's statement in Danforth that the record-keeping requirement:

> . . . if not abused or overdone, can be useful to the state's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment. (Emphasis added.) 428 U.S. at 81.

It is apparent that a lesser standard of review was

utilized by this Court in evaluating the constitutionality of the regulation.

Interpreting the standard to be applied in determining whether or not a regulation was valid, this Court, in Bellott I, supra, 428 U.S., at 147, noted that in Danforth, it had been:

> . . . held that a requirement of written consent on the part of a pregnant adult is not unconstitutional unless it unduly burdens the right to seek an abortion." (Emphasis added).

The unduly burdensome standard of review enunciated by this Court in Danforth and Bellotti I was said, in Maher v. Roe, 432 U.S. 464, 473 (1977), to balance the woman's interest against the nature of the state's interference in exercising that right. In Maher, the Court noted that:

> Whalen [v. Roe, 429 U.S. 589 (1977)], makes clear, the right in Roe v. Wade can be understood only by considering both the woman's interest and the nature of the State's interference with it. 432 U.S. at 473.

As decided by the District Court:

> An absolute prohibition of first trimester abortions could only be justified by a compelling state interest. Likewise, regulations that afford the power to veto a woman's decision to terminate her pregnancy must be supported by a compelling state interest. See Danforth, 428 U.S. at 67-72. Regulations that interfere with a woman's privacy to a

> lesser degree, however, require a lesser showing by the state to withstand constitutional attack . . . (App. 88a-89a).

Accordingly, the Court must determine the degree that each section of Ordinance Number 160-1978 interferes with a woman's constitutional right, in consultation with her physician, to choose to terminate her pregnancy. That interference must then be weighed against any valid state interest furthered by such section.

B. The Court of Appeals erred in prohibiting all direct regulation of first-trimester abortions.

In applying a two-tier analysis to the Akron abortion ordinance, the Court of Appeals incorrectly interpreted prior decisions of this Court, especially in light of the recent decisions of Matheson, supra, and Thone v. Womens Services, P.C., _____ U.S. _____, 69 L. Ed. 2d 414 (1981), and in effect held all first-trimester regulation to be impermissible.

Initially, the Appellate Court looked to "the nature of the particular regulatory provision," inquiring as to whether or not the regulation had a "'legally significant impact or consequence' on the right of a pregnant woman, in consultation with a physician, to choose to terminate her pregnancy." Accordingly, if there was no legally significant impact or consequence, no constitutional issue was

raised. Where the regulation resulted in a legally significant impact or consequence, the Court further required that the "regulatory provision serve a legitimate and compelling state interest." But, only if a compelling state interest were found would it further inquire as to whether the regulation imposed an "undue burden" on the abortion decision. (App. 9a).

This "two-step analysis" required by the Court of Appeals also provided that first trimester regulations are per se invalid if they result in a legally significant impact or consequence, holding as a matter of law that the state has no compelling interest during the first trimester. (App. 9a). Such a standard of review goes far beyond the prior decisions of this Court allowing the direct regulation of first-trimester abortions. Connecticut v. Menillo, 423 U.S. 9 (1975); Danforth, supra; Matheson, supra; Thone, supra.

Recently, in Matheson, this Court upheld a requirement of prior parental notice where a minor seeks an abortion. The Court recognized that:

> As applied to immature and dependent minors, the statute plainly serves the important considerations of family integrity and protecting adolescents which we identified in Bellotti II . . . The Utah statute is reasonably calculated to protect minors in

> appellant's class by enhancing the potential for parental consultation concerning a decision that has potentially traumatic and permanent consequences. (Emphasis added). 450 U.S. at 411.

In so holding, this Court apparently did not apply a compelling state interest test. But even if such a test must be met, it is implied that the state has such an interest in this and all other first-trimester abortion regulations which have been held constitutional by this Court.

Of key importance is the fact that the regulation was one imposed on first-trimester abortion decisions and one which resulted in a legally significant impact, and, yet, the regulation was constitutionally permissible. Unquestionably, a statute requiring parental notification of a minor's decision to have an abortion results in a legally significant impact on the minor's constitutionally protected decision. The regulation, therefore, is not unconstitutional merely because it has a legally significant impact on the first-trimester abortion decision.

II. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE MINOR'S HEALTH BY REQUIRING PARENTAL OR JUDICIAL CONSENT TO AN IMMATURE,

UNEMANCIPATED MINOR'S ABORTION.

Section 1870.05(B) of the Akron ordinance is directed at minors unable to give an effective consent and in so regulating it does not provide anyone with an "absolute veto." Section 1870.05(B) provides that the consent of one parent or the legal guardian must be obtained prior to an abortion upon a pregnant minor under the age of fifteen years or, in the alternative, a court may provide consent where the parents or guardian are either unavailable or refuse consent. This section has been prematurely held unconstitutional as no mature minor under the age of fifteen is challenging the overbreadth of the regulation.

The Supreme Court first addressed the issue of requiring a parent's consent to a minor's abortion in Danforth, supra, 428 U.S., at 72-75, in which it was held that a blanket requirement that an unmarried girl obtain parental consent to an abortion was unconstitutional as it imposed an absolute veto power over a minor's decision to have an abortion.

This Court, when faced with a similar regulation requiring parental consent to a minor's abortion in Bellotti II, supra, stated that there must be an alternative procedure whereby authorization for the abortion can be obtained. This Court provided that:

> . . . if the state decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure[22] whereby authorization for the abortion can be obtained . . . n. 22 . . . we discuss the alternative procedure described in the text in terms of judicial proceedings. We do not suggest, however, that a state choosing to require parental consent could not delegate the alternative procedure to a juvenile court or an administrative agency or officer. Indeed, much can be said for employing procedures and a forum less formal than those associated with a court of general jurisdiction. 443 U.S. at 643.

The Akron ordinance provides such an "alternative procedure" whereby authorization for the abortion can be obtained in accordance with the constitutional requirements enunciated by this Court in Bellotti II. Section 1870.05 does not purport to determine either the nature of the judicial alternative or the procedure to be followed in such cases, as state law provides a mandatory procedure to be followed in juvenile proceedings under Chapter 2151 of the Ohio Revised Code and the Ohio Rules of Juvenile Procedure. (App. 130a). As such provisions were not constitutionally challenged "as applied" to judicial proceedings in which a minor seeks an abortion, and since the District Court made no finding as to their operation and effect, these

provisions cannot form the basis for holding that Section 1870.05(B) is unconstitutional.

The City of Akron is prohibited under the Ohio Constitution from legislating in areas in which the state has enacted general laws. Ohio Const. Art. XVIII, Section 3. Any attempt by the City to so legislate would be a nullity under Ohio law. Lies v. Cleveland Ry, Co., 101 Ohio St. 162, 128 N.E. 73 (1920). Akron v. Scalera, 135 Ohio State 65, 19 N.E. 2d 279 (1939). As the statutory provisions governing juvenile judicial proceedings were not constitutionally challenged in these proceedings, the Akron ordinances should properly be reviewed in light of a constitutional judicial alternative.

A. LACK OF STANDING

As Judge Kennedy noted in her dissenting opinion:

> Section 1870.05(B) is capable of a construction that would render it constitutional. This would be the case if, for example, the order from "a court having jurisdiction" was based, as it constitutionally must be, first on an inquiry into the minor's maturity. Thus, the section is not facially invalid. As the majority notes in reversing the District Court's holding that section 1870.05(A) is unconstitutional, no minor challenges the Akron ordinance. I would not find section 1870.05(B) unconstitutional until a mature minor challenges it and until it has been construed by a lower court.

Thus, it is not to be assumed that during the course of the juvenile proceedings the Court will not construe the ordinance in a manner consistent with the constitutional requirement of a determination of the minor's ability to make an informed consent. Indeed it is abundantly clear that there is no one better able to determine a minor's maturity and hence her ability to make a decision regarding abortion. Admittedly the abortion clinics are not making any such determination. (Tr. VII, 166, 174).

So construed, the regulation is constitutionally permissible. Unless and until the section is challenged by a minor who claims to be mature or emancipated, a holding that Section 1870.05(B) is unconstitutional would be improper and premature. In Bellotti I, supra, and in Matheson, supra, this Court refused to strike down legislation on its face without a state court's determination as to construction and application of the laws in question.

The constitutional challenge by the plaintiff in Matheson, based upon overbreadth, was denied as she lacked standing to advance the argument. This Court noted: "We need not reach that question since she did not allege or proffer any evidence that either she or any member of her class is mature or emancipated. 450 U.S. 405-406.

The overbreadth argument was not subject to

review under such circumstances as the statute was capable of a constitutional construction. This Court stated:

> In Bellotti I, supra, we unanimously declined to pass on constitutional challenges to an abortion regulation statute because the statute was 'susceptible of a construction by the state judiciary which might avoid in whole or in part the necessity for federal constitutional adjudication, or at least materially change the nature of the problem.' Id., at 147, quoting Harrison v. NAACP, 360 U.S. 167, 177 (1959). See Kleppe v. New Mexico, 426 U.S. 529, 546, 547 (1976); Ashwander v. Tennessee Valley Authority, 297 U.S. 288, 346-347 (1936)(concurring opinion). We reaffirm that approach and find it controlling here insofar as appellant challenges a purported statutory exclusion of mature and emancipated minors. 450 U.S. at 407.

While the statute in Matheson dealt with parental notification rather than parental or judicial consent, the principles enunciated by this Court are equally applicable in the present case. [See also, New York v. Ferber, _____ U.S. _____, _____ (1982)].

B. Important State Interest in Protection of Minors

Recently, this Court vacated the decision of the Court of Appeals, in Thone, supra, wherein it had held a parental consultation requirement to be unconstitutional. In vacating the Court of Appeals'

decision in Thone, this Court remanded for reconsideration in light of the recent decision in Matheson, supra.

The Court in Matheson recognized that:

> As in Bellotti I, supra, 'we are concerned with a statute directed toward minors, as to whom there are unquestionably greater risks of inability to give an informed consent.' Id., at 147. 450 U.S. at 411.

The Utah statute requiring parental notification of a minor's decision to have an abortion was upheld. The opinion quoted at length from the dissenting opinion in Bellotti II, where four Justices joined in stating:

> (Plaintiffs) suggest . . . that the mere requirement of parental notice (unduly burdens the right to seek an abortion). As stated in Part II above, however, parental notice and consent are qualifications that typically may be imposed by the State on a minor's right to make important decisions. As immature minors often lack the ability to make fully informed choices that take account of both immediate and long-range consequences, a State reasonably may determine that parental consultation often is desirable and in the best interest of the minor. It may further determine, as a general proposition, that such consultation is particularly desirable with respect to the abortion decision—one that for some people raises profound moral and religious concerns.

* * *

> 'There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child. That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support. It seems unlikely that she will obtain adequate counsel and support from the attending physician at an abortion clinic, where abortions for pregnant minors frequently take place. Id. at 640-641, quoting Danforth, supra, 428 U.S. at 91 (concurring opinion), (footnoes omitted). Accord, id. at 657 (dissenting opinion).'

While the initial decision in Danforth, provided that a state may not constitutionally legislate a blanket power of parents to veto their daughter's decision to have an abortion, that holding "does not suggest that every minor regardless of age or maturity, may give effective consent for termination of her pregnancy." 428 U.S., at 75, citing Bellotti I, supra.

Indeed this Court has recognized that the states have a compelling state interest in the wellbeing of a minor. Most recently in New York v. Ferber, _____ U.S. _____, _____ (1982), this court declared that "it is evident beyond the need for elaboration that a

state's interest in safeguarding the physical wellbeing of a minor is 'compelling.' Globe Newspapers v. Superior Court, _____ U.S. ___, _____ (1982)." This court went on to recognize that:

> Accordingly, we have questioned legislation aimed at protecting the physical and emotional wellbeing of youth even when the laws have operated in the sensitive area of constitutionally protected rights. Id. at _____.

Section 1870.05(B), on balance, does not unduly burden an immature, unemancipated minor's constitutionally protected right to seek an abortion, even if it must be exercised via an alternative procedure whereby authorization for the abortion can be obtained. Bellotti II, supra, 443 U.S., at 643. The parental or judicial consent requirement, however, would also meet the more stringent compelling state interest test should that be required, as states have a compelling state interest in safeguarding the physical wellbeing of minors.

III. THE STATE HAS A LEGITIMATE INTEREST IN INSURING INFORMED CONSENT.

Section 1870.06(B) provides that an attending physician must inform a woman prior to an abortion of several factors, including that she is pregnant, the number of weeks elapsed, information regarding fetal development, possible complications, that abortion is a major surgical procedure, and the availability of

agencies to assist her. This requirement is designed to protect the woman and ensure that her consent will be truly informed. Such a provision strikes a reasonable balance between the woman's right of privacy and the state's interest in maternal health and ensuring the informed consent of the patient. Maher, supra, 432 U.S., at 473.

Contrary to Respondents' allegations in the courts below, nothing in this section denies the physician flexibility, as Section 1870.06(C) expressly permits the physician to:

> . . . provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

The District Court made no findings of fact regarding the subsections involved. Its decision was simply based upon its ruling that the state cannot "specify what each patient must be told." By requiring the physician to provide the information, the City is protecting the woman's right to make the abortion decision in consultation with her physician.

Section 1870.06(B) was struck down in its entirety by the District Court notwithstanding that several subsections are clearly constitutional. Subsections (1), (2), (6), and (7) are doubtless rationally related to a woman's maternal health and

do not unduly burden her decision to have an abortion. Such subsections should have been severed from any subsections found to be unconstitutional.[9]

Subsections (1), (2), (6), and (7) provide respectively that prior to the giving of an informed consent, a woman is to be told by her attending physician (1) that she is pregnant, (2) the number of weeks that have elapsed from the probable time of conception, (3) that there are numerous public and private agencies available to her with birth control the state and tailor the comprehensive information and that, upon request, the physician will give her a list of such agencies and the services available, and (4) that there are numerous public and private agencies which are available to assist her during pregnancy and after the birth of her child if she choose not to have an abortion and that, upon request, the physician will provide her with a list. Not only are these requirements not unconstitutional, but they contain information necessary for a patient to make an informed decision.

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[9]"Should any provision of this Chapter be construed by any court of law to be invalid, illegal, unconstitutional, or otherwise unenforcible, such invalidity, illegality, unconstitutionality, or unenforceability shall not extend to any other provision or provisions of this Chapter (Section 1870.19).

While the Respondents contend that requiring such information to be given would impermissibly interfere with a woman's right to decide to terminate her pregnancy, it is important to note that the information contained in Subsection 1870.06(B)(1), (2), (6), and (7) is currently being provided to patients at the Respondent clinics. (Tr. III, 144-148).

Thus the only possible interference lies in the fact that the physician is required to provide such information rather than unlicensed counselors. Such an interference, if in fact it is one, does not unduly burden the woman's access to an abortion or her decision-making process. Rather, it insures the physician's consultation that has been recognized by this Court in Roe, supra, 410 U.S., at 153, 163-165.

An informational requirement, such as that contained in the Akron ordinance, was recently approved in a footnote by this Court in Matheson. The statute under review in that case provided that no abortion could be performed

> . . . unless a 'voluntary and written consent' is first obtained by the attending physician from the patient. In order for such a consent to be 'voluntary and informed' the patient must be advised at a minimum about available adoption services, about fetal development, and about foreseeable complications and risks of an abortion.' 450 U.S. at 400.

The Court summarily affirmed an informed consent provision in Franklin v. Fitzpatrick, 428 U.S. 901 (1976), which affirmed the three-judge District Court's decision in Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (1975). The District Court, in upholding the provision, noted that:

> In that event, while telling a patient that the law requires such advice, the Act does not foreclose the physician from putting this statement in perspective for a given patient by reassurances, or by comparing the risks of other options. Proper counseling, it would appear, could incorporate the information demanded by advice to the individual case. 401 F. Supp. at 588.

The district court quite liberally applied the severability clause, Section 1870.19, to numerous sections, even severing words and phrases out of sentences, and yet refused to apply severability to Section 1870.06(B) which could have been severed quite easily in accordance with the intent of the framers of Chapter 1870. In failing to sever such subsections, the courts below ignored the clear legislative intent as expressed in Section 1870.19.

The test to determine severability as stated by the District Court in Wynn v. Scott, 449 F. Supp. 1302, (N.D. Ill. 1978), is: (1) are the sections so intertwined that structurally and logically a constitutional defect in one will taint the remainder;

(2) what is the will of the legislature; (3) is the statute a product of impermissible state purpose; that is, does every section, in fact, discourage and frustrate the abortion decision; and (4) is it possible to predict what the legislature would do if part of the act were held unconstitutional?

The subsections are not so intertwined that any defects in subsections 3, 4, and 5 taint the remainder. If severed, 1870.06(B) will be completely comprehensible and will clearly inform a physician of what must be told a woman prior to obtaining her informed consent. The informational requirement aids the patient in making a truly informed decision.

Even assuming a compelling state interest should be required to uphold the regulation, such an interest should be found in regulations protecting the physician-patient relationship that was the foundation of the decision in Roe.

IV. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING PHYSICIAN-PATIENT COUNSELING PRIOR TO THE ABORTION.

The decision rendered by this Court in Roe recognizes that the abortion decision is to be made in consultation with the woman's physician. 410 U.S., at 153, 163-165. Section 1870.06(C) seeks to protect the woman's right to make an informed decision in

consultation with her physician by requiring that the attending physician inform the pregnant woman:

> . . . of the particular risks associated with her own pregnancy and the abortion technique to be employed, including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery; and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

In reversing the District Court's finding that this section was constitutional, the Court of Appeals stated that "Section 1870.06(C) impinges on the medical judgment of the attending physician . . ." (App. 15a). No finding, however, was made that the section interfered with the woman's right to decide to have an abortion in consultation with her physician.

The core of the constitutional protection recognized in Roe, supra, is the woman's right to have an abortion in consultation with her physician. This constitutional protection does not guarantee "a physician freedom to practice medicine free of state regulation." (App. 84a). The privacy of Roe v. Wade, is not simply a right of personal privacy or a "right to your own body," but the privacy of the relationship between the woman and her physician,

just like the privacy of the marital relationship in Griswold v. Connecticut, 381 U.S. 479 (1965).

Section 1870.06(C) was enacted to ensure that the consultation protected in Roe v. Wade actually takes place. As stated previously, it is the current practice of Akron abortion clinics not to provide such consultation between physician and patient. (App. 87a). The necessity for consultation prior to the abortion, however, was undisputed.

Respondent's contention that Section 1870.06(C) is unconstitutional is not addressed to the content of the information required therein to be provided. Rather, the challenge is to the requirement that the information be provided by the physician. This section does not interfere with the woman's fundamental right to decide whether to terminate her pregnancy. Rather, it ensures the participation of the attending physician in a vital decision. The physician-patient relationship is an essental component of the woman's constitutional right to decide to have an abortion, as made clear by the decisions of this Court. Respondents seek to remove the attending physician from the picture; yet they seek to rely upon the privacy of the physician-patient relationship. However, absent physician involvement in the abortion decision, the rationale of Roe falls. This is reflected in the case of Menillo, supra,

wherein this Court upheld criminal sanctions imposed against violators of a state statute which prohibited anyone other than a physician from performing an abortion.

This Court therein stated:

> Even during the first trimester of pregnancy, therefore, prosecutions for abortions conducted by non-physicians infringe upon no realm of personal privacy secured by the Constitution against state interference.

The giving of the information contained in Section 1870.06(C) "enhances, rather than restricts, the woman's freedom of choice." (Dissenting opinion), (App. 35a). Such information does not confine the physician's discretion, but simply reitereates his common law and ethical duty. An abortion regulation interferes with the woman's right only if it imposed a "restriction on access to abortions that was not already there." Maher, supra, 432 U.S., at 474. This court has repeatedly recognized the importance of the physician-patient relationship to the abortion decision. Roe v. Wade, supra, 410 U.S., at 163, 164; Danforth, supra, 428 U.S., at 61; Bellotti II, supra, 443 U.S., at 641 n. 21, 643. In Colautti v. Franklin, 439 U.S. 379, 387 (1979), this court observed that:

> Roe stressed repeatedly the central role of the physician, both in consulting

with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out.

As noted by Judge Kennedy in her dissenting opinion, "the Supreme Court apparently does not believe that the limited information required by .06(C) imposes an undue burden on the physicians." (App. 35a).

The argument that such a requirement intereferes with a physician's medical judgment was rejected in Planned Parenthood Assn. v. Fitzpatrick, 401 F. Supp. 554 (1975), aff'd. sub nom., 428 U.S. 901 (1976). Therein the court stated:

> To the extent the requisite information respecting the alternatives to abortion are inappropriate in any particular case, the physician is not prohibited from so indicating to the patient en passant. A doctor may conclude that, in his or her professional judgment, it is unlikely that a patient will experience detrimental physical and psychological effects which are not foreseeable. In that event, while telling a patient that the law requires such advice, the Act does not foreclose the physician from putting this statement in perspective for a given patient by reassuring, or by comparing the risks of other options. Proper counseling, it would appear, could incorporate the information demanded by the state and tailor the comprehensive advice to the individual case.

Section 1870.06(C) of the Akron ordinance does not impermissibly interfere with the physician-patient relationship fundamental to the right to decide to have an abortion. Rather, it furthers a valid state interest in the health of its female citizens and assures that the woman's consent will be truly informed. Furthermore, removal of the physician from the function of providing counseling, including information as to risks and aftercare, would certainly promote the important interest of the state in the woman's health to a "compelling" status, regardless of the stage of pregnancy.

In summarizing the situation, Judge Kennedy in her dissenting opinion, stated:

> The requirement that the information specified in .06(C) be given by a physician does no more than seek to ensure that there is in fact a true physician-patient relationship even for the woman who goes to an abortion clinic. The evidence presented at trial showed that the decision to terminate a pregnancy was made not by the woman in conjunction with her physician, but by the woman and lay employees of the abortion clinic, the income of which is dependent upon the woman's choosing to have an abortion. The testimony disclosed that the doctors at Akron Center's clinic did little, if any, counseling before seeing the patient in the procedure room. Akron's ordinance simply takes into account these realities of the 'physician-patient'

relationship at an abortion clinic.

V. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE WOMAN'S HEALTH BY REQUIRING A TWENTY-FOUR HOUR WAITING PERIOD.

By delaying the effectuation of the abortion decision, a reasonable balance is struck between the state's important interest of ensuring careful consideration of that decision by the woman and the woman's right to decide to have an abortion. The District Court, in accordance with the standard of review ennunciated by this Court, found that the regulation did not unduly burden the woman's constitutional rights. (App. 99a). In reaching this decision, the District Court held that Section 1870.07 furthered the important state interest of insuring "that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation." (App. 99a).

In reversing the District Court, the Court of Appeals applied an overly stringent standard of review to the regulation, in conflict with the standard enunciated by this Court. Danforth, supra; Bellotti I, supra,; and Matheson, supra.

The Court of Appeals stated that "since Section 1870.07 causes a legally significant impact or consequence on the abortion decision, it cannot be

applied to first-trimester abortions." (App. 17a). The Court of Appeals, thus, invalidated this section only because it impacted on decisions to have an abortion during the first three months of pregnancy. The proper standard of review, as discussed earlier, requires that in considering the regulation the focus be placed on the burden imposed on the woman's decision to have an abortion. Danforth, supra; Bellotti I, and Matheson, supra.

A parental notification requirement was upheld by this Court in Matheson, even though it resulted in a legally significant impact on the minor's constitutionally protected decision to have an abortion during the first trimester of pregnancy. In so holding, this Court noted:

> That the requirement of notice to parents may inhibit some minors from seeking abortions is not a valid basis to void the statute as applied to appellant and the class properly before us. The Constitution does not compel a State to fine tune its statutes so as to encourage or facilitate abortions. To the contrary, state action 'encouraging childbirth except in the most urgent circumstances' is 'rationally related to the legitmate governmental objective of protecting potential life.' Harris v. McRae, supra, _____ U.S. at _____. Accord, Maher v. Roe, supra, 432 U.S. at 473-474. 450 U.S. at 413.

Clearly not all regulations applicable to first

trimester pregnancies are invalid because they have a legally significant impact.

Following the decision in Matheson, this Court vacated the judgment of the Eighth Circuit Court of Appeals in Thone, supra, wherein a forty-eight-hour waiting period had been held unconstitutional. In vacating the judgment, this Court remanded the case to the Court of Appeals for reconsideration in light of its decision in Matheson. It is apparent that a first-trimester regulation is not automatically invalid.

Respondent's medical expert, Dr. Crist, testified that the waiting period would not create a significant risk to the patient's physical health. (Tr. I, 82, 94, and 118). Additionally, Dr. Bowen, who was also called as a witness for the Respondents, testified that it is preferable and better medical practice to separate counseling and the procedure by twenty-four hours or more. (Tr. II, 65). Dr. Hoffman, another of Respondent's witnesses, testified that a twenty-four hour waiting period is desirable in most instances and that a twenty-four hour delay is not critical. (Tr. III, 147 and 168). Both Dr. Sim and Dr. Schmidt, President of the American College of Obstetrics and Gynecology, testified that the twenty-four hour waiting period (and even a seventy-two hour delay) is not significant in terms of risk and is desirable in

terms of time to reflect. (Tr. VIII, 42; X 12 and 26). The section is thus drawn so as not to impose an undue burden on the patient.

In Wolfe v. Schroering, 541 F. 2d 523 (6th Cir. 1976), the Sixth Circuit Court of Appeals upheld a twenty-four hour waiting period. The court stated:

> Nor do we view the Ky. Rev. Stat. 426.023 24-hour waiting period requirement between the woman's consent and the abortion as being unconstitutional. The district court invalidated the waiting period requirement because 'it attempts to regulate the abortion procedure during the first trimester, during which time the state has no compelling interest and thus can pass no regulation affecting this period.' Danforth, supra, _____ U.S. at _____, 96 S. Ct. at 2839-2840, 49 L. Ed. 2d at 803-804, rejected similar reasoning. Given the imprecision of the trimesters and 'viability,' a delay of 24 hours could not result in a transition from the first into second trimester, or from the second trimester into 'viability.' See Rodos v. Michaelson, 396 F. Supp 768, 771, 772 (D.R.I.), rev'd on other grounds, 527 F. 2d 582 (1st Cir. 1975). Nor do plaintiffs claim that the 24 hour waiting period significantly burdens the abortion process. Moreover, Section 436.023 contains an exemption for abortions where 'an emergency situation presents imminent peril substantially endangering the life of the woman.' 541 F. 2d at 526.

Clearly, Section 1870.07 is constitutional under

the Wolfe rationale. The testimony at trial showed not only that no significant danger is created by a twenty-four hour wait, but that the patient will actually benefit from such wait. The patient will have the time to mull over the information which she receives during counseling.

Further, the District Court, in upholding the waiting period recognized that the Respondents in this case claimed that the regulation "signficantly burdened the abortion process." (App. 98a).

The District Court, however, in accordance with the standard of review enunciated by the Court, found that the regulation did not unduly burden the woman's constitutional rights. This was so even though the Court believed the regulation would serve to make effectuation of the abortion decision more expansive. The Court held that the regulation served the important state interest of ensuring that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation. Section 1870.07 does impose a restriction on a woman's access to an abortion and serves an important state interest in protecting the woman's informed decision.

VI. THE TERM "HUMANE" AS USED IN SECTION 1870.16 IS NOT UNCONSTITUTIONALLY VAGUE.

The courts below found Section 1870.16 to be unconstitutionally void for vagueness. This was due to the fact that the section which deals with the disposal of the remains required that it be done in a humane and sanitary manner. The District Court found that the word "humane" was void for vagueness. The overall intent of the section is, as was noted in Planned Parenthood Assn. v. Fitzpatrick, 401 F. Supp. 554, 573 (1975), aff'd Franklin v. Fitzpatrick, 428 U.S. 901 (1976), "to preclude the mindless dumping of aborted fetuses on garbage piles." In Fitzpatrick, the three-judge District Court upheld a regulation which provided that the Department of Health make regulations for the humane disposal of remains.

The language used in this section was largely taken from a state regulation which provides that "the fetus shall be disposed of in a humane manner." 3 Ohio Administrative Code 3701-47-05 1979. In light of the intent of Section 1870.16, it is clearly not void for vagueness.

Even if the term "humane" were found to be void for vagueness, the entire section should not have been struck down. By severing the term "humane" and allowing the balance to remain, the District Court would have insured two goals: (1) that potential criminal liability could not be founded on an

ordinance which local abortion clinics might have difficulty construing and (2) that the health and safety of the Akron community would be furthered by providing for the sanitary disposal of the fetus. It can hardly be doubted that the health of the community would be furthered by such a requirement and that such a regulation is reasonably within Akron's power. Fitzpatrick, supra.

In addition, by so severing the section the courts below would have been following the manifest intent of the City Council which had provided in Section 1870.19 that a finding of unconstitutionality of one provision was not to result in the striking of the entire ordinance. Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932).

CONCLUSION

Therefore, the appropriate disposition of this case is to reverse the decision of the Court of Appeals as to Sections 1870.06(C) and 1870.07, and remand for an affirmance of the decision of the District Court as to those sections. As to Sections 1870.05(B), 1870.06(B), and 1870.16 the decision of the Court of Appeals should be reversed.

Dated July _____, 1982

Respectfully submitted,

ROBERT D. PRITT
Director of Law
The City of Akron
304 Municipal Building
Akron, OH 44308-1655
(216) 375-2031

Attorney for Petitioner

Nos. 81-746 and 81-1172

Office - Supreme Court, U.S.
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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.,

Cross-Petitioners,

—v.—

CITY OF AKRON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENTS AND CROSS-PETITIONERS' BRIEF

JANET BENSHOOF
SUZANNE M. LYNN
NAN D. HUNTER
American Civil Liberties Union Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44155
(212) 687-2328
(*Counsel of Record*)

Attorneys for Respondents and Cross-Petitioners

QUESTIONS PRESENTED

Questions presented for review to this Court by Petitioner, Defendant City of Akron appear in Defendant's Brief, p. i.

Questions presented for review to this Court by Cross-Petitioner, Plaintiffs are:

1. Whether this Court's summary affirmance of *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894 (N.D.Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934, (1981), compelled the United States Court of Appeals for the Sixth Circuit to uphold an ordinance of the City of Akron, Ohio mandating that all abortions after the first trimester of pregnancy be performed in hospitals accredited by the Joint Commission on Accreditation of Hospitals.

2. Whether the requirement that all second trimester abortions be performed in hospitals, regardless of the techniques used or the stage of gestation, is unconstitutional because it unnecessarily burdens women needing such abortions and their physicians and is not narrowly drawn to further legitimate maternal health interests.

PARTIES

Petitioner, the City of Akron, was Defendant below with John Ballard, Mayor; Dr. C. William Keck, Director of Public Health; and Peter Oldham, Prosecutor. Defendant-intervenors in the trial court were Dr. Francois Seguin and Mrs. Kathleen Black who were permitted to intervene solely in their capacity as parents of unmarried minor daughters of child bearing age. Plaintiffs below, Akron Center for Reproductive Health, Inc.; Akron Women's Clinic, Inc.; WomenCare, Inc.; and Dr. Robert Bliss, a physician representing himself and the rights of adult and minor patients needing abortions in Akron, are Respondents and Cross-petitioners in this litigation.

TABLE OF CONTENTS

PAGE

QUESTIONS PRESENTED i

PARTIES ii

TABLE OF AUTHORITIES vii

OPINIONS BELOW 1

JURISDICTION 1

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 1, 13a-14a

STATEMENT OF THE CASE 2

A. History of the Legislation 2

B. History of the Litigation 5

C. Facts 6

1. Introduction 6

2. The Requirement That All Second Trimester Abortions Be Performed in Hospitals Endangers Health Because Hospitals Are Unavailable and Early Second Trimester Abortions Are Safely Performed in Outpatient Clinics 9

3. Section 1870.05(B) Provides No Alternative To A Parental Veto and Endangers the Health and Well-Being of Minors 13

4. Sections 1870.06(B) and (C) Force the Attending Physician To Give Each Patient Distorted and Erroneous Information 15

PAGE

5. The Inflexible 24-Hour Waiting Period Senselessly Imposes Physical, Emotional, and Economic Burdens On Women Needing Abortions in Akron 20

SUMMARY OF ARGUMENT 22

ARGUMENT:

I. CONSISTENT WITH PRINCIPLES OF JUDICIAL REVIEW, THE SIXTH CIRCUIT COURT OF APPEALS CORRECTLY APPLIED THIS COURT'S STANDARD FOR REVIEWING STATUTES WHICH IMPINGE UPON FUNDAMENTAL PRIVACY RIGHTS 25

A. This Court Has Consistently Applied the Compelling State Interest Test Established in *Roe v. Wade* 25

B. Strict Scrutiny Provides a Clear Standard of Review 28

C. It is Essential for Federal Courts to Safeguard Constitutional Rights 29

II. THE AKRON ORDINANCE RESTRICTIONS VIOLATE A WOMAN'S RIGHT TO PRIVACY WHICH ENCOMPASSES HER RIGHT TO CHOOSE ABORTION 32

A. The Forced Speech Requirements of Section 1870.06(B) and (C) Distort the Decision-Making Process and Unconstitutionally Burden the Abortion Decision 32

B. The Mandatory Waiting Period in Section 1870.07 Promotes No State Interest and Would Cause Serious Hardships 37

PAGE

C. The Post-First Trimester Hospital Requirement of Section 1870.03 Unnecessarily Burdens Women and Does Not Further Any Legitimate Maternal Health Interests 40

D. The Fetal Disposal Requirement of Section 1870.06 is Unconstitutionally Vague 43

III. SECTION 1870.05(B) IS NOT PROPERLY BEFORE THIS COURT BECAUSE NO PARTY WITH ARTICLE III STANDING APPEALED TO THE COURT OF APPEALS 45

IV. THE PARENTAL CONSENT REQUIREMENT IS UNCONSTITUTIONAL BECAUSE IT PROVIDES NO JUDICIAL ALTERNATIVE FOR MATURE OR BEST INTERESTS MINORS 47

CONCLUSION 50

APPENDIX A—Description of Witnesses 1a

APPENDIX B—Standards for Obstetric-Gynecologic Services, 5th Edition, 1982, Published by the American College of Obstetricians and Gynecologists. Gynecology-Ambulatory Care, page 16 ..... 5a

APPENDIX C—American Public Health Association Resolution, "The Right to Second Trimester Abortion," Adopted November, 1979 ..... 7a

APPENDIX D—National Medical Committee of the Planned Parenthood Federation of America. Standards for Early Midtrimester Abortion in Planned Parenthood Affiliates. Revised, March, 1980 9a

PAGE

APPENDIX E— State Laws Restricting Second Trimester Abortions To Hospitals..... 11a

APPENDIX F— Constitutional Provisions Involved... 13a

TABLE OF AUTHORITIES

Cases: PAGE

Adickes v. S.H. Kress & Co., 398 U.S. 144 (1970) 45

Aware Woman Clinic, Inc. v. City of Cocoa Beach, C. No. 77-361-Drl-Civ.-4 (M.D. Fla. April 21, 1978).... 39

Barry v. District of Columbia Board of Elections and Ethics, 580 F.2d 695 (D.C. Cir. 1978) 25, 46

Bellotti v. Baird, 428 U.S. 132 (1976).....25, 27, 28

Bellotti v. Baird, 443 U.S. 622 (1979)...23, 27, 47, 48, 49, 50

Bigelow v. Virginia, 421 U.S. 809 (1975) 37

Brown v. Board of Education of Topeka, 347 U.S. 483 (1954) 31

Brown v. Board of Education of Topeka, 349 U.S. 294 (1955) 31

California v. Taylor, 353 U.S. 553 (1957)..... 45

Carey v. Brown, 447 U.S. 455 (1980) 37

Carey v. Population Services International, 431 U.S. 678 (1977) 27, 28, 40, 41, 48

Champlin Refining Co. v. Corp. Commission of Oklahoma, 286 U.S. 210 (1932).....24, 33, 45

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In re Corey, 145 Ohio St. 413, 61 N.E.2d 892 (1945)... 48

Colautti v. Franklin, 439 U.S. 379 (1979) 27, 43, 44

Connecticut v. Menillo, 423 U.S. 9 (1975)..... 26

Cooper v. Aaron, 358 U.S. 1 (1958)..... 31

Craig v. Boren, 429 U.S. 190 (1976) 25, 47

Dandridge v. Williams, 397 U.S. 471 (1970) 49

PAGE

In re Decertification of Eastlake, 66 Ohio St.2d 363, 422 N.E.2d 598 (1981) 34

Doe v. Bolton, 410 U.S. 179 (1973) 26, 34, 39

Doremus v. Board of Education, 342 U.S. 429 (1952) .. 46

Edelman v. Jordan, 415 U.S. 651 (1974) 41

Eisenstadt v. Baird, 405 U.S. 438 (1972) 48

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Flast v. Cohen, 392 U.S. 83 (1968) 48

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Gertz v. Robert Welch, Inc., 418 U.S. 323, 343 (1974) . 29

Glick v. List, CV-R-81-150 (BRT) (D. Nev. July 7, 1981) 39

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H__ L__ v. Matheson, 450 U.S. 398 (1981) 25, 28, 47

Harris v. McRae, 448 U.S. 297 (1980) 26, 27

Legal Aid Society of Alameda County v. Brennan, 608 F.2d 1319 (9th Cir. 1979), *cert. denied*, 447 U.S. 921 (1980) 46

Leigh v. Olson, 497 F. Supp. 1340 (D.N.D. 1980) 39

Kovacs v. Cooper, 336 U.S. 77 (1949) 37

PAGE

Maher v. Roe, 432 U.S. 464 (1977) 27

Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803) 29

Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La. 1980) 39, 42

Michael M. v. Superior Court of Sonoma County, 450 U.S. 464 (1981) 14, 15

Mobile Women's Medical Clinic v. Board of Commissioners, 426 F. Supp. 331 (S.D. Ala. 1977)..... 39

Munson v. Meirhenry, No. 80-3043 (D.S.D. Feb. 27, 1981)..... 39

O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) 24, 45

Orr v. Knowles, CV-81-0-301, CV-81-167 (D. Neb. May 30, 1981)..... 39

Palko v. Connecticut, 302 U.S. 319 (1937)..... 30

Paul v. Davis, 424 U.S. 693 (1977) 30

Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (E.D. Pa. 1975), *aff'd mem. on other grounds sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).....43, 44

Planned Parenthood Association of Kansas City, Missouri v. Ashcroft, 655 F.2d 848; *supplemented* 664 F.2d 687 (8th Cir. 1981) *cert. granted*, 50 U.S.L.W. 3934 (U.S. May 24, 1981) (Nos. 81-1255, 81-1623) ...2, 33, 39, 42

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).....*passim*

Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1981).....32, 33, 39

PAGE

Planned Parenthood of Memphis v. Alexander, No. 78-2310 (W.D. Tenn. March 23, 1981) 39

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Public Utilities Commission v. Pollak, 343 U.S. 451 (1952) 37

Rhodes v. Doctors Hospital North, 18 O.O.3d 391, 394 (Ct. App. Franklin Co. 1980) 35

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Singleton v. Wulff, 428 U.S. 106 (1976) 48

Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26 (1976) 46

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PAGE

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Wynn v. Carey, 599 F.2d 193 (7th Cir. 1979) 39

Constitutions, Statutes and Rules:

U.S. Const. art. III, §§ 1, 2 ..... 1, 25

U.S. Const. amend. I 1, 36

U.S. Const. amend. XIV 1, 24

28 U.S.C. § 1254(1) 1

Fed. R. Civ. P. 24(b)(2) 46

Ohio Const., art. XVIII, § 3 1

Ohio Rev. Code Ann. § 2151.03 (Baldwin 1981) 1, 48-49

Ohio Rev. Code Ann. § 2151.23 (Baldwin 1981) 1, 48-49

Ohio Rev. Code Ann. § 2151.28 (Page 1976) 1, 49

Ohio Rev. Code Ann. § 2151.33 (Baldwin 1981) 1, 49

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Ohio Admin. Code § 3701:47-01 (1977) 1, 42, 43

Ohio Admin. Code § 3701:47-05 (1977) 1, 43

PAGE

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PAGE

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PAGE

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OPINIONS BELOW

(See brief of Defendant, City of Akron)

JURISDICTION

The Judgment of the United States Court of Appeals for the Sixth Circuit was entered on June 12, 1981. The court of appeals denied all parties' petitions for rehearing by July 22, 1981. Defendant-Intervenors' petition for writ of certiorari was denied on May 24, 1982. Defendants' petition for writ of certiorari was filed on October 13, 1981 and granted on May 24, 1982. Plaintiffs' cross-petition for writ of certiorari was filed December 19, 1981 pursuant to Associate Justice O'Connor's order of October 16, 1981, extending the time for filing. Plaintiffs' cross-petition for writ of certiorari was granted on May 24, 1982. This Court's jurisdiction is invoked under Title 28, U.S.C. Section 1254 (1).

CONSTITUTIONAL AND STATUTORY PROVISIONS

1. *United States Constitution*, Article III, Sections 1,2.
   United States Constitution, Amendment I
   United States Constitution Amendment XIV, Section 1.
2. *Ohio Constitution Article XVIII, Section 3.*
   (For text of above, See Appendix F to this brief)
3. *The City of Akron Ordinance, Number 160-1978*
   Reprinted in the appendix to Defendants' petition for writ of certiorari. (Pet. A pp. 115a-129a)

4. The pertinent parts of the Ohio Revised Code Chapters 2151, 3109, 2317, 2919 and the Ohio Revised Administrative Code: Chapter 3701-47 are reprinted in the Joint Appendix at pp. 325a-339a and p. 299a.

STATEMENT OF THE CASE

A. History of the Legislation

Clinics and physicians in the City of Akron, Ohio, provide needed abortion services for women from all over northeast Ohio, and from as far away as Columbus, Ohio, and West Virginia. (Goldberger, T. VI, 116.)[1] In 1977, the year before this ordinance was enacted, more than 95% of all abortions in Akron were performed by the three plaintiff clinics.[2] No one disputed that the clinics had an excellent health care record and, as Defendant Dr. C. William Keck, Director of Health of the City of Akron, stated, the rate of major complications "could hardly be lower." (P.Ex. 48, J.A. 309a.)

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[1] The following designations are used to refer to the documents filed with this Court in this litigation: "J.A."—Joint Appendix; "T."—Transcript of the district court proceedings (with the volume number preceding the page number, i.e., V, 116); "R."—Record item (numbered according to the list of items transmitted to this Court); "Ex./T." refers to the transcript pages at which the exhibit was offered and admitted into evidence (these references appear in the J.A. for those exhibits contained within it), pursuant to Supreme Court Rule 34 (.5). The lower court opinions in this case are reproduced in the appendix to the Petition for Certiorari ("Pet.A."). Since the most recent United States government statistics available at the trial of this case in 1978 were from 1975 (Crist, T.I, 34), plaintiffs also refer to the certified record of a related case before this Court, *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft*, U.S. S.Ct., Nos. 81-1255, 81-1625; "Ash.A."—Joint Appendix of *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft*. For the Court's convenience, frequently referred to exhibits from *Ashcroft*, as well as recent medical and statistical publications, are reproduced in a volume lodged with this brief. ("L.doc."). L.doc. 1/Ash. D.Ex. 1 (on remand) refers to an exhibit submitted in the *Ashcroft* trial on remand and in the certified record before this Court. A list of witnesses and their credentials is provided in Appendix A to this brief.

[2] The three plaintiff clinics, Akron Center for Reproductive Health, WomenCare, and Akron Women's Clinic performed approximately 5,280 of the 5,574 reported abortions performed in Akron in 1977 (P.Ex. 48, J.A. 309a; Gottshall, T.II, 8-9; Goldberger, T.II, 148; Hurst, T.III, 26.)

The clinics' excellent health care record was verified through an ongoing audit and review by the medical community of Summit County, Ohio, in which the City of Akron is located. From the time the clinics opened in late 1976 to the time the present litigation began in April 1978, the clinics were inspected and approved by eight different officials and organizations, including Defendants Dr. Keck, Dr. Ernest Estep, medical director of the Planned Parenthood Association of Summit County, and Dr. Charles V. Bowen, ranking obstetrician-gynecologist of the Summit County Medical Society.[3] (P.Ex. 50, J.A. 317a; P.Ex. 48, J.A. 304a; P.Ex. 51, J.A. 320a; Parker, J.A. 169a; Crossman, J.A. 218a.) Further, the clinics met the rigorous medical referral standards of Planned Parenthood Federation of America, the Summit County Medical Society, and various public welfare agencies. (P.Ex. 50, J.A. 317a-318a; P.Ex. 51, J.A. 320a; Crossman, J.A. 218a.)

Prior to the enactment of this criminal statute, first trimester abortions were regulated in Akron in the same manner as all other medical services.[4] (P.Ex. 48, J.A. 306a.) The Akron Health Department had, according to its director, "full authority to deal with all matters concerning the public health and sanitation." (*Id.* at J.A. 306a.) In addition, the medical community established a voluntary audit and review committee focused exclusively on the clinics. It inspected them, offered recommendations, and did "follow-up inspections." (P.Ex. 50, J.A. 317a.)

In October 1977, a bill was introduced in the Akron City Council to regulate abortion in the City of Akron. (P.Ex. 42/T.II, 246, 247; Segedy, T.II, 219.) The drafters and sponsors

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[3] Dr. Bowen visited each clinic at least twice. (P.Ex. 50, J.A. 317a.) Separate inspections were conducted by the Stark County Planned Parenthood Association, the Summit County Welfare Department, and the Ohio Welfare Department. (Parker, J.A. 169a; Crossman, J.A. 218a.)

[4] Defendant Dr. Keck, stated that there were "268 physicians and dentist sub-specialists practicing in Akron who may perform one or more of many surgical procedures in their offices with risk comparable to abortion. . ." (P.Ex. 48, J.A. 310a.)

neither visited the clinics nor examined medical statistics concerning abortion care in Akron and were wholly unfamiliar with the informed consent and counseling practices of the Akron clinics. (Segedy, J.A. 145a-146a; Kapper, J.A. 204a-205a.) The drafters' intent, according to one of their number, was to prepare and enact a "national model" anti-abortion ordinance. (Weinberger, R. 171, p. 39/J.A. 322a.)[5]

Between October 1977 and February 1978, the Akron City Council considered the proposed legislation. A series of drastic departures from normal legislative procedure punctuated the deliberations. Selected councilmen held a secret meeting to hear testimony in favor of the ordinance; the public and council members opposed to the ordinance were excluded from this meeting. (Weinberger, R. 171, pp. 98-99/J.A. 323a.) Chapter 1870 was one of only two ordinances considered by the Council over at least a three year span not drafted by the city law department (Brooks, J.A. 173a), and the only bill enacted in that period contrary to the advice of the city law department's representative to the Council that the bill was, in large measure, unconstitutional. (Brooks, J.A. 176a.) It was the only ordinance in recent memory which was redrafted in City Council committee sessions attended by outsiders, i.e., the original drafters of the "model anti-abortion" ordinance. (Brooks, J.A. 172a; Segedy, J.A. 146a.) Finally, Chapter 1870 was enacted without distributing copies of the final text to council members prior to the final vote. One member of the council admitted this was "very unusual." (Brooks, J.A. 177a.)

Chapter 1870 was adopted despite evidence showing no medical or health-related need for it. Defendant Dr. Keck, Akron Director of Health, stated:

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[5] Because it was drafted as a "model," Chapter 1870 contains several provisions inapplicable to Akron, including § 1870.13, which bans abortions in "municipal hospitals." As the chief councilman-sponsor of the bill testified, Akron has never had a municipal hospital or similar facility and has no plans to build one. (Kapper, J.A. 205a.)

> From the point of view of protecting the health of women involved, there is no compelling reason to regulate Akron's abortion facilities. If data exists of sufficient quality to contradict that which is available to me, I'd be pleased to evaluate it. (P.Ex. 48, J.A. 309a.)[6]

The ordinance passed by a vote of seven to six and became law without the signature of the Mayor of the City of Akron, Defendant John Ballard, who stated:

> I don't believe any credible evidence has been advanced to suggest that adequate and proper medical standards and procedures are being ignored in Akron. Therefore, I don't believe it has been demonstrated, from a medical standpoint, that further regulation is necessary. Further, it appears to me that the thrust of this ordinance may run counter to now well-established case law, in that it possibly invades constitutionally guaranteed rights of women who desire to have an abortion. (P.Ex. 51, J.A. 320a.)

However, he declined to veto the bill, stating: "I don't feel I should presume to decide these questions [the legality and constitutionality of the ordinance]—the courts are the proper place for the resolution of questions of law." (*Id.*)

B. The History of the Litigation

Plaintiffs rely on the procedural overview presented in defendants' brief, except for three corrections. First, defendants never appealed the district court's invalidation of Section 1870.05(B), requiring parental consent. Only the defendant-intervenors appealed this section to the Sixth Circuit Court of Appeals. (See Sec. III, p. 45, *infra.*) Second, defendants concede the unconstitutionality of subsections (3), (4), and (5) of Section 1870.06(B). (D.Brief, p. 37; D.Brief to the Sixth Circuit Court of Appeals, at 9-10, 35-36.) Third, defendants

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[6] Dr. Charles Bowen, speaking on behalf of the Summit County Medical Society, also concluded that, "there is no medical need for an ordinance to be introduced." (P.Ex. 50, J.A. 317a.)

mischaracterize the questions on which plaintiffs' cross-petition for certiorari was granted. (D.Brief, p. 3.) The correct Questions Presented appear at page (i).

In addition, plaintiffs note that the district court denied the separate motions of a pregnant woman and of a doctor who worked at one of plaintiff clinics, to proceed as plaintiffs under pseudonyms, and that these orders were affirmed by the Sixth Circuit Court of Appeals. (R. 15, 23, 26, J.A. 53a, 57a; Pet.A. 22a.)

C. Facts

1. Introduction.

The legalization of abortion has produced dramatic improvements in the health of American women and children. Since having become a legal medical procedure, abortions are being performed safely, at reduced costs, and with constant improvement in techniques and procedures. Today, abortion is both the most frequent form of minor surgery, and also one of the safest.[7]

From 1972 to 1978, abortion-related deaths (legal and illegal) fell by 70%, with a similar decline in complications. (L.doc. 1, p. 3, 4/Ash. D.Ex. 1 (on remand).)[8] Mortality rates

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[7] Comparative data from one of the plaintiffs' expert witnesses, Dr. Crist, established that the mortality rate for a first trimester abortion is about 1.2 per 100,000 procedures (T.I, 120), with a mortality rate of only .5 per 100,000 for those abortions performed under 8 weeks gestation. (Tietze, T.IV, 156.) In comparison, the mortality rate for childbirth ranges from 10 to 71.4 per 100,000, depending on age (T.I, 35), and for simple tooth extraction, 174 per 100,000 procedures. A penicillin shot carries a risk of 1.4 to 2 deaths per 100,000 patients. (Crist, J.A. 90a.) The risk of having to undergo major surgery for an abortion complication is approximately one one-hundredth that of having to undergo major surgery for a complication resulting from carrying a pregnancy to term. (L.doc. 1, p. 5/Ash. D.Ex. 1 (on remand).)

[8] United States government epidemiologists have recently determined that one-third or more of the women who died from legal abortion between 1972 and 1978 had medical conditions considered so potentially life-threatening that a therapeutic abortion would have been justified. (L.doc. 4, p. 190.)

have declined primarily because legal abortion is safer than any other alternative available to pregnant women. Expert testimony at the trial established that first trimester abortions are from 8 to 35 times safer than childbirth. (Crist, J.A. 90a.)[9] Furthermore, health risks of pregnancy and childbirth are greatly exacerbated when a pregnancy is unwanted. (L.doc. 1, p. 4/Ash. D.Ex. 1 (on remand).)

Delay is the most serious factor increasing the risk of an abortion. For every one week of delay, the risk of mortality increases about 50% and the risk of morbidity (serious complications), about 20%. (Tietze, T.IV, 156.) One major reason for the increased safety of abortion over the past ten years is that women are getting abortions at progressively earlier gestational ages.[10]

Despite the critical medical importance of prompt access to abortion services, most women in the United States cannot obtain abortions from their ordinary source of medical care. In 1980, only 10% of all obstetrician-gynecologists in private practice reported performing abortions in their offices; only 17% of all the public hospitals in the United States and 34% of the private hospitals reported doing at least one abortion.[11]

These national statistics reflect the situation in Akron, Ohio. There are no public hospitals, three of the five private hospitals

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9 Two government studies recently published in the *Journal of the American Medical Association* (See L.docs. 4 & 5) further support this conclusion, finding that the risk comparisons between abortion and childbirth underestimate the relative safety of abortion for pregnant women. For all ages, childbearing has a higher risk of death than abortion. And, while the risks of pregnancy vary with age, abortion risks remain lower and essentially constant across age groups (Crist, T.I, 35; Heald, T.II, 71-72).

10 In 1978, 52% of all abortions were performed in the first eight weeks of pregnancy, when the mortality rate is only .05 per 100,000 abortions. (L.doc. 2, p. 4/Ash.A. 88.)

11 Henshaw, *Abortion Services in the U.S. 1979-1980*, 14 Fam. Plan. Persp. 6, 11, 12 (1982) (L.doc. 7). Furthermore, only 22% of all abortions take place in hospitals, and only 32% of the hospitals that provide abortions will do any abortions after 14 weeks of pregnancy. (*Id.* at 15.)

do no abortions, and the other two hospitals report very few. (Stipulation, J.A. 197a; P.Ex. 47, J.A. 301a-303a; P.Ex. 46, J.A. 300a.) At the time of trial in 1978, second trimester abortions were not available in hospitals in Akron. (Gotshall, J.A. 113a.)

Because abortions are rarely available in hospitals, ambulatory facilities have developed to meet this special need.[12] In 1973, over 60% of all abortions were performed in hospitals. In contrast, by 1979, over 70% of all abortions were performed in free-standing clinics. (L.doc. 1, p. 8/Ash. D.Ex. 1 (on remand).)[13] This trend benefits women needing abortions, since the quality of care provided in specialized clinics is generally very high, and the average cost of an abortion in a clinic is much less than the cost of an abortion in a hospital. (L.doc. 1, p. 8/Ash. D.Ex. 1 (on remand).)

In spite of this beneficial trend, the unavailability of abortion providers is a continuing problem.[14] This problem will only be exacerbated by statutes, such as Chapter 1870, which use criminal sanctions to discourage doctors from performing abortions and to harass women seeking abortions. Doctors who wish to practice conscientiously and avoid the risks of criminal prosecution will simply decline to do abortions.

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12 Abortion is only one type of surgery done increasingly on an ambulatory basis in clinics. See Foster, *Ambulatory Gynecologic Surgery*, in Ambulatory Care in Obstetrics and Gynecology 399 (G. Ryan 1980).

13 In 1980, 76% of all abortions were performed in clinics and hospitals serving 1,000 or more abortion patients per year. (L.doc. 7, p. 10.)

14 The Alan Guttmacher Institute estimated that, nationwide, 29% of the women in need of abortion services were unable to obtain them in 1979. (L.doc. 6.) These women have been unable to obtain abortion services, in part, because of the continued inaccessibility of abortion facilities; 78% of U.S. counties and 59 Standard Metropolitan Statistical Areas had no facilities in which legal abortions were performed in 1980. (L.doc. 7, pp. 5, 10.)

2. The Requirement That All Second Trimester Abortions Be Performed in Hospitals Endangers Health Because Hospitals Are Unavailable and Early Second Trimester Abortions Are Safely Performed in Outpatient Clinics.

Section 1870.03 requires that every abortion performed subsequent to the end of the first trimester be performed in a hospital.[15] The evidence demonstrated that this requirement serves no health interests because early second trimester abortions performed in clinics are as safe as, or safer than, those performed in hospital facilities; that Akron hospitals are not available to meet the need for second trimester abortions; and that the hospital requirement imposes severe burdens on women by making second trimester abortions more expensive, more time-consuming, and less geographically accessible. The Sixth Circuit Court of Appeals found decisions invalidating identical provisions on the basis of such proof, "persuasive." (Pet.A. 21a.)

In 1972, the accepted medical practice was to perform abortions after the first trimester by the use of instillation techniques.[16] Recent research and practical experience throughout the United States have demonstrated that a medical technique called dilatation and evacuation ("D&E")[17] is now the preferred technique for second trimester abortions, particu-

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15 As defined by § 1870.01(B), this means "a general hospital or special hospital devoted to gynecology or obstetrics which is accredited by the Joint Commission on Accreditation of Hospitals, or by the American Osteopathic Association."

16 The two main instillation techniques are saline amniocentesis and prostaglandin amino infusion. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75 (1976). In 1973, saline instillation procedures accounted for 80% of all second trimester abortions. (Ash.A. 46.)

17 D&E is an extension of the first trimester dilatation and curettage procedure. It typically involves use of small forceps for the removal of fetal material, a suction cannula for the aspiration of amniotic fluid and placental and fetal debris, and a surgical curette to ensure complete evacuation. (Crist, T.I, 30.)

larly those up to 18 weeks of pregnancy. Development of the D&E procedure has significantly increased the safety, convenience, and speed of second trimester abortions and has also reduced costs.

Second trimester abortions by D&E are more than twice as safe as those performed by the instillation method (Crist, J.A. 91a),[18] and much safer than childbirth. (L.doc. 3, pp. 402, 404/Ash.A. 81, 83.) By 1978, D&E abortions accounted for 51% of all second trimester procedures. (L.doc. 3, p. 401/Ash.A. 79.) In the 13th to 15th weeks of pregnancy, the former "gray zone,"[19] 82% of all abortions were performed by the D&E method. (L.doc. 2, p. 4/Ash.A. 90.)

Both statistical evidence and expert testimony at trial demonstrated that early second trimester D&E abortions may not only be safely performed in qualified non-hospital facilities, but, in some circumstances, may actually be safer in clinics. (Crist, J.A. 93a; Kerenyi, J.A. 212a; L.doc. 3, p. 406/Ash.A. 85.)[20] By 1980, the vast majority of second trimester D&E

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18 The latest government statistics from the U.S. Center for Disease Control show that mortality risks from saline abortions are well above the risks of the D&E procedure. (L.doc. 2, p. 49/Ash.A. 94.) Government statistics concerning morbidity presented at the trial of this case in 1978 showed that early second trimester abortions done by the D&E method were more than 160% safer than instillation procedures. (P.Ex. 48, J.A. 315a.)

19 The D&E method does away with the "gray zone," the period between 13-15 weeks gestation, when it is too late for a first trimester vacuum suction procedure, but too early for instillation procedures. Thus, women in their thirteenth week of pregnancy are no longer forced to incur significant health risks by postponing an abortion for three or more weeks until an instillation procedure can be performed. (Crist, J.A. 89a, 92a.)

20 Plaintiffs' expert, Dr. Crist, testified that performing a D&E in a free-standing clinic maximizes safety for the patient because most physicians in free-standing clinics have extensive experience in performing D&E's. In a hospital setting, patients are more likely to be treated by inexperienced physicians in training. (Crist, J.A. 93a; Ash.A. 48, 58-59.) In addition to the safety of clinic abortions, clinics generally are more sensitive to the woman's mental health needs. (Hofmann, J.A. 167a.) Clinic personnel, unlike hospital staff, are selected and trained to serve abortion patients, and the clinics

procedures were performed in non-hospital facilities. (Ash.A. 46.)[21]

The standards of major medical organizations reflect the fact that early second trimester abortions are safe and desirable clinic procedures. In 1981, the American College of Obstetricians and Gynecologists (ACOG) endorsed the provision of early second trimester abortions in outpatient clinics, stating:

> Generally, abortions in the physician's office or outpatient clinic should be limited to 14 weeks from the first day of the last menstrual period. In a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility, abortions should be limited to 18 weeks from the last menstrual period. (See 1982 ACOG manual of standards, p. 16, Appendix B to this brief.)

The College's now obsolete policy recommending that second trimester abortions be performed only in hospitals, was the only proof offered by the defendants to support the in-hospital requirement. (Schmidt, T.X, 29; Pet.A. 19a.)[22]

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provide trained abortion counselors. Dr. Hofmann testified that the very best of counseling and support systems are available in the free-standing abortion clinics, while hospital personnel are often insensitive, particularly to adolescent needs. (J.A. 167a; American Public Health Association Resolution, Nov. 1979, Appendix C to this brief at 7a.)

21 This figure would be much higher, but for the fact that sixteen states have laws in effect which limit second trimester abortions to hospitals. Such laws have been enjoined in six additional states. (See Appendix E to this brief.)

22 In 1979, the American Public Health Association also endorsed second trimester abortions in qualified clinics. See *APHA Recommended Program Guide for Abortion Services* (revised 1979, 70 Am. J. Pub. Health 652, 654 (1980)), Appendix C to this brief. Similarly in 1980, the National Medical Committee of the Planned Parenthood Federation of America (PPFA) changed its standards to hold that qualified affiliate clinics could provide abortions by D&E through the 18th week of pregnancy. (Appendix D to this brief.) Studies examining the health impact of "hospital-only"

The ban on the performance of second trimester abortions in Akron clinics imposes a substantial burden on women needing second trimester abortions. The Sixth Circuit Court of Appeals found:

> There was unrebutted testimony that there were only two hospitals in Akron in which second trimester abortions were being performed. During the year preceding trial, [1977] only nine such abortions were performed in these two hospitals. It was testified that approximately 10% of the 6,000 women who sought abortions in the Akron clinics during the same period were in their second trimester of pregnancy. Many of these women were referred to clinics in Cleveland, Ohio, and in the State of Michigan. Those who were unable to travel to those places were faced with the choice of carrying the baby to term, attempting self-abortion, or seeking illegal abortions. The mortality and morbidity incidence of self-abortions and illegal abortions greatly exceeds that of the second trimester D&E procedure. (Pet.A. 19a.)

Furthermore, unrebutted testimony at the time of trial in 1978 established that no second trimester abortion services were available in Akron hospitals. (Gotshall, J.A. 113a.) Finally, the hospitalization rule greatly increases costs of abortion. The circuit court pointed out that, "a second trimester abortion in a hospital costs $850-$900, while total charges for a D&E abortion in a clinic are $350-$400." (Pet.A. 20a.)

These burdens fall disproportionately on teenage, poor, and minority women who are most likely to need second trimester abortions, and are least able to pay for hospitalization or travel. (Tietze, J.A. 199a-200a.) As the court of appeals concluded, "[w]ithout the ability to travel and the funds to pay for the hospital treatment, many . . . Akron women have no real opportunity to obtain an abortion." (Pet.A. 19a.)

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requirements, sponsored by the United States Centers for Disease Control and published in medical and scientific journals, endorse the safety of second-trimester abortions in clinics and state there is no reason for rigid in-hospital requirements. (L.doc. 3, p. 406/Ash.A. 85; L.doc. 8, p. 772.)

3. Section 1870.05(B) Provides No Alternative to a Parental Veto and Endangers the Health and Well-Being of Minors.

Section 1870.05(B) prohibits physicians from performing abortions for minors under age 15, unless the physician has first obtained the consent of one of her parents,[23] or the minor has obtained a court order. This requirement is contrary to the practice followed by the City of Akron in providing other medical care to minors. Parental consent or notification is not required for the prenatal care and venereal disease treatment provided by the City of Akron. (Keck, J.A. 209a-210a.)

Defendants suggest this requirement is needed because all minors under 15 are "immature." (D.Brief 5, 24.) This is simply wrong. The director of one clinic testified that 25-30% of the patients under 15 were knowledgeable and well-informed about abortion and its consequences, and more than 50% about its alternatives. (Gotshall, T.I, 186-187; see also, Hofmann, T.III, 164, 165; Heald, J.A. 132a: "there are some 14 year olds who are mature enough to make the decision.") Even defendants' own expert testified that he had some 14 year old patients who were mature enough to make a decision. (Williams, J.A. 281a.)

There is no question, however, that parental involvement helps most pregnant minors, and in fact, parents are involved in the overwhelming majority of cases. A four month survey taken in 1978 by Akron Center for Reproductive Health indicated that of the 29 women 14 years of age, 26 came with a parent; and, of the seven younger women, every one was accompanied by a parent. (Gotshall, T.I, 159-160; P.Ex. 17, J.A. 287a.)[24]

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[23] Read in conjunction with §§ 1870.06 and 1870.07, this means the parents must personally receive all the mandated information at least 24 hours ahead of the abortion procedure.

[24] The results of this survey are consistent with testimony from other facilities. See Goldberger, J.A. 143a (most patients under 17 come to Akron Women's Clinic with parents); Parker, J.A. 168a (most patients under 15 who go to Planned Parenthood for pregnancy counseling are accompanied by a parent); and Hurst, T.V, 214 (two-thirds of minors go to WomenCare with a parent.).

The few Akron teenagers who do not involve their parents have extremely good reasons for not doing so: some are afraid of "additional physical abuse," others fear harming a "terminally ill parent." (Bolitho, J.A. 153a; Goldberger, J.A. 143a.) Physical violence is particularly prevalent where pregnancy results from rape by the father. (*See* Crist, J.A. 99a.) The incidence of incest-related pregnancy in young teens is quite high. One witness testified that in a study he had done involving 400 abortion patients, of the 17 girls age 12 and under, 11 were pregnant because of incest. (Crist, J.A. 99a.)[25] Apart from situations in which there is a risk of physical violence, the experts testified that parental reactions will sometimes cause significant emotional injury to the pregnant teenager, or damage the family relationships. (Crist, J.A. 99a-100a; Heald, T.II, 82, 104; Hofmann, J.A. 159a-160a.) Furthermore, some parents will veto an abortion regardless of the best interests of the minor. (Black, J.A. 222a; Seguin, J.A. 240a.)

The irreparable effects of teenage pregnancy were recognized by this Court in *Michael M. v. Superior Court of Sonoma County*, 450 U.S. 464 (1981). A young teenager suffers from a much higher risk of mortality if she goes through pregnancy and childbirth than she does getting an abortion. (Heald, T.II, 71; J.A. 129a.)[26] It is well-documented that teenagers seek abortions later in their pregnancies than older women, and that any such delay increases health risks. (Heald, J.A. 129a-130a; Hofmann, J.A. 158a.) Because of § 1870.05(B), some young women will seek abortions in other localities, thereby increasing the risks associated with inadequate follow-up care; others will opt for illegal or self-abortion; and still others will attempt suicide. (Crist, J.A. 102a, 103a ; Heald, T.II, 83; Hofmann, J.A. 158a-159a.)[27]

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[25] An administrative assistant in the Medical Department of the Summit County Welfare Department testified that she had counseled an incestuously impregnated minor under the age of 15 in the month before trial. (Crossman, J.A. 218a.)

[26] From 1977-1978, the maternal death rate among mothers under age 15 was 18 per 100,000 live births. (Alan Guttmacher Institute, *Teenage Pregnancy: The Problem That Hasn't Gone Away* (1981); L.doc. 14, p. 29.)

[27] Approximately one-fourth of female minors who attempt suicide do so because they are, or believe they are, pregnant. (Teicher, *A Solution to the*

The most harmful effects of § 1870.05(B) may not be strictly medical. To force motherhood on a 13 or 14 year old girl, whose parents will not (or cannot) help or support her, will change her entire future. (Heald, T.II, 73-74; Crist, J.A. 110a.) Most teenage mothers do not finish high school; about 60% of mothers aged 15-17 are on welfare within two to five years of the birth of their children. *Michael M.*, 450 U.S. at 479 n.9 (Stewart, J., concurring.). And the children born to these children face greatly increased risks of death in infancy, retardation, cerebral palsy, epilepsy, and learning disability. (Crist, J.A. 110a; Heald, T.II, 74-76; Hofmann, T.III, 166-167.)[28]

4. Sections 1870.06(B) and 1870.06(C) Force the Attending Physician to Give Each Patient Distorted and Erroneous Information.

Sections 1870.06(B) and 1870.06(C) of the Akron Ordinance mandates the "attending"[29] physician to present a prepared script, and forecloses the exercise of any professional judgment. (Pet.A. 15a.)

Most women who come to the Akron clinics seeking an abortion have had both counseling and referral assistance before they ever contact the clinics.[30] At the Akron clinics, each

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Chronic Problem of Living; Adolescent Attempted Suicide, in Current Issues in Adolescent Psychiatry 129, 136 (J. Schoolar ed. 1973). *See, e.g.*, the case of a pregnant 17 year old in Ohio who attempted suicide by shooting herself in the abdomen because she did not have the $600 cash needed to pay for an abortion in a Cleveland hospital. *Suicide Attempt Failure for Teen, But Fetus Dies*, The Plain Dealer, July 28, 1979, at 5a, col. 1.)

28 The offspring of incest victims have a high likelihood of deformity and/or death, even if the parents are normal. (See Adams & Neal, *Children of Incest*, 40 Pediatrics July 1967 at 55; L.doc. 16, p. 59.)

29 The term "attending physician" used in § 1870.06 is not specifically defined. (See IIA, p. 35 n.59, *infra*.)

30 For example, Akron Center for Reproductive Health Director of Counseling, Yvonne Bolitho, testified that "approximately two-thirds to three-fourths of our patients have been seen by other professionals, and have been counseled before they come to us." (Bolitho, J.A. 151a; see also Parker,

woman is informed orally and in writing of the risks of the abortion procedure, signs an informed consent form, is instructed in techniques of birth control, and is provided aftercare instructions before the abortion is ever performed.[31] Defendants' claim that the doctor neither counsels nor consults with his patients (D.Brief, p. 10.) is contrary to the evidence. (Pet.A. 47a.) The physician performing the abortion reviews the patient's medical chart with her, talks with her about her questions and concerns, and does a pelvic examination. (Gotshall, T.I, 151; Goldberger, J.A. 139a-140a; Hurst, T.III, 13-15, 30-31.) If the doctor detects any ambivalence, he will "suggest that [the patient] return at another time, after she [has] had some additional time to consider alternatives to abortion." (Dr. Bliss, T.VII, 108; Dr. C., T.VII, p. 11-12; Gotshall, T.I, 149-150.)

Sections 1870.06(B) and .06(C) prohibit the attending physician from exercising any medical judgment to delegate birth control, welfare, or risk-counseling to other professionals. Yet,

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J.A. 168a; Crossman, J.A. 216a; Gotshall, J.A. 112a; Goldberger, T.VI, 102.) Both plaintiffs' and defendants' witnesses agreed that the vast majority of women have decided to have an abortion prior to coming to an abortion clinic. (See Heald, T.II, 115; Dr. C., J.A. 232a; Schmidt, T.X, 88.)

31 The counselors at all three clinics are experienced in family planning and pregnancy counseling. Counselors at ACRH must have a college degree, preferably in psychology or sociology, and previous experience in counseling. (Gotshall, T.I, 175.) They are trained extensively by ACRH before they are allowed to counsel patients, and they receive continuing in-service training. (Bolitho, T.III, 67.) Training includes reading medical literature on abortion, family planning and sexuality, observing counseling sessions, and counseling under the supervision of the director of counseling. (Gotshall, T.I, 129.) Each patient spends at least one hour with these counselors; part of this time is spent in reviewing the informed consent form. (Gotshall, T.I, 149.) Counselors at Akron Women's Clinic undergo similar training. In addition, a patient there does not sign the consent form until she has had an individual session with a registered nurse who explains the form to her. (Goldberger, T.II, 134-136.) At WomenCare, both a counselor and a registered nurse will review each part of the informed consent form with individual patients to insure that the patient understands each of the possible complications. (Hurst, T.III, 30-31.)

there was testimony that delegation of such counseling can better serve the needs of the patient, because doctors are not always the best equipped to do counseling, particularly in regard to an unwanted pregnancy. (Hofmann, J.A. 167a, T.III, 153; Kerenyi, J.A. 213a.)[32]

Section 1870.06(B) requires every physician to recite specific information, most of which is either irrelevant, misleading, threatening, inaccurate, or impossible to ascertain. For example, subsections 1870.06(B)(1) and (2) require that every woman be told that she is pregnant and the number of weeks that have elapsed from the time of conception; this is not always possible. These requirements would preclude doctors from performing menstrual extractions, i.e., abortions done at about four weeks of pregnancy before a pregnancy test generally can be done. (Crist, J.A. 88a.)[33]

Section 1870.06(B)(3) requires that the attending physician orally inform each patient that the "unborn child" is "a human life from the moment of conception," and describe in limitless detail the "anatomical and physiological characteristics of the particular unborn child . . . " including "appearance, mobility, tactile sensitivity. . . . " There was no medical or scientific agreement that life begins at conception,[34] and some of the

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32 The district court found that requiring doctors to do all this counseling will increase the cost of abortion. (Pet.A. 97a.) Further, there are very few physicians who perform abortions in Akron; and the few who do, have only been willing to devote a limited amount of time to performing abortions. (Goldberger, J.A. 141a-143a, 224a-225a; Bliss, J.A. 215a.)

33 The definition of abortion used by the U. S. Center for Disease Control includes menstrual extractions; "any intervention to terminate a suspected pregnancy (whether or not the pregnancy is later confirmed)." (P.Ex. 69, p. 5/T.I., 39.)

34 Theological experts testified that the particular view of the beginning of human life expressed in § 1870.06(B) is a religious one, not shared by everyone, and that being forced to say these statements would interfere with some doctors' free exercise of religion. (McKeenan, T.II, 215, 216; Weist, T.V, 131, 132; Wood, T.V, 34.) Plaintiff Dr. Bliss testified that the mandated statement about the beginning of human life was contrary to his own beliefs,

details required exceed the bounds of what is presently available from medical science.[35] Further, the medical experts testified that giving the detailed description of the fetus can be "cruel, heartless, and so overwhelming," that it is likely to produce anxiety and guilt in a number of patients. (Hofmann, T.III, 138; Heald, T.II, 88; Katz, T.IV, 113.) This description is intended to impress upon the woman that abortion is equivalent to murder.[36]

Section 1870.06(B)(4) compels the attending physician to tell each patient at every stage of her pregnancy that if more than 22 weeks of pregnancy have elapsed, "her child" might be viable, and that "her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion." Since at least 99% of abortion patients in Akron are under 14 weeks pregnant, this material is irrelevant and will confuse many women. (Katz, T.IV, 113.)

The district court found that defendants were unable to prove that the information required by § 1870.06(B)(5) was entirely true. (Pet.A. 95a.) Four of the possible "serious" complications specified in § 1870.06(B)(5) are simply unsup-

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and he would have a great deal of difficulty in complying with the requirement. (T.V, 110, 113.)

35 The district court found that it is impossible for the doctor to determine many of these required details, such as the "unborn child's" sensitivity to pain (Pet.A. 96a.), and that the "including, but not limited to," language is so vague that the physician simply cannot know how much detail to include. (Pet.A. 96a n.26.)

36 One of the defendants' witnesses explained how the mandated words will yield this result:

> "product of conception, fetal tissue, globe of protoplasm, fetal placental unit and other high sounding phrases are all direct denials of the humanity of the growing child. Make up your mind. If you are convinced that this is a human life, call it such. Then consistently speak of he or she, not it, and speak of an unborn, pre-born, or developing child or baby. It is easier to approve killing of a fetus, much more so than killing of an unborn baby." (Wilke, J.A. 277a.)

ported by any credible evidence.[37] Section 1870.06(B)(5) also forces the doctor to state that abortion is a "major surgical procedure" when, as found by the district court, abortion is generally considered a "minor surgical procedure." (Pet.A. 95a, 86a.)

Four of the eight serious complications listed in § 1870.06(B)(5) are possible, though extremely rare: hemorrhage, perforated uterus, infections, and sterility.[38] These complications are already explained to the patient and are contained in the informed consent forms. (P.Ex. 10, J.A. 285a; P.Ex. 32, J.A. 292a; P.Ex. 37, J.A. 297a.)

Subsections (6) and (7) of § 1870.06(B) require the physician to tell every woman that numerous public and private agencies are available to help her with birth control, prenatal care and adoption, and to provide help after "the birth of her child." The doctor is not an expert on these matters, nor is it always true that such help is actually available.[39]

The requirements distort the goal of informed consent, which is intended to give patients information so that they can have a "greater role to play in the medical, decision-making process." (Katz, J.A. 190a.) Subsections 3, 4, and 5 constitute

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37 Aside from extremely rare occurrences, there is no medical evidence that abortion causes "menstrual disturbances," "miscarriage and prematurity in subsequent pregnancies," and "severe emotional disturbances." (Crist, T.I, 76; Katz, T.IV, 114-115; Tietze, T.IV, 155-156.) Medical studies subsequent to the trial of this case find no increase in the risk of miscarriage or prematurity subsequent to abortion. (L.doc. 13, p. 551, L.doc. 11, pp. 83-84.) For women with existing psychological problems, "relief far exceeds the number of difficulties." For healthy women, the risk of post partum depression is five times higher than the risk of psychiatric disturbance following abortion. (David, T.IV, 62-66; Bliss, T.V, 113.)

38 The complication of "sterility" is presented in a misleading way. Sterility is not a separate complication. It arises as a complication from an infection or because a hysterectomy was performed as a treatment for an uncontrolled hemorrhage. (Tietze, T.IV, 153-155.)

39 Some of the Akron abortion patients are referred to the clinics after being counseled at the Summit County Welfare Department (Crossman, J.A. 216a.), where they may have learned that no help is available.

a one-sided presentation of all the possible (and impossible) risks, physical and psychological, of an abortion. Nowhere is the p[illegible] informed that the risks of an abortion are much less than the risks of a continued pregnancy. (Crist, T.I, 78; Heald, T.II, 97.) Thus, the informed consent dialogue is transformed into an anxiety-producing ordeal for the woman, and the doctor becomes the enemy of his patients by being forced to articulate "distasteful" and "dishonest" propositions. (Crist, J.A. 106a; Katz, J.A. 193a.) The requirements of §§ 1870.06(B) and (C) do not allow the physician, under any circumstance, to exercise any medical, professional judgment to forego some of the information, either at the patient's request or on the basis of his own good sense.[40] Defendants' experts agreed on the need for such flexibility, and stated that they would not personally force information on a woman. (Seguin, J.A. 238a-239a; Sim, J.A. 274a-275a; Wilke, J.A. 276a; Schmidt, T.X, 53.) The district court found that the inflexibility of these requirements places the physician in the " 'undesired and uncomfortable straitjacket' warned against by the Supreme Court." (Pet.A. 96a.)

5. The Inflexible 24 Hour Waiting Period Senselessly Imposes Physical, Emotional, and Economic Burdens on Women Needing Abortions in Akron.

Section 1870.07 mandates a 24 hour delay between the time a woman signs the consent form and performance of the abortion. The waiting period is designed to work in conjunction with § 1870.06; every patient is required to wait at least 24 hours to "mull over the information she receives during counseling." (D.Brief, p. 47.)

The court of appeals found that the defendant presented no evidence "that an inflexible requirement of a 24-hour waiting

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[40] Dr. Katz testified that, in the interest of preserving patient health and well-being, it is sometimes medically appropriate to go forward without detailing all the risks, and that there are studies that indicate between 11-17% of all patients do not want to know "a great deal about what is in store for them." (J.A. 190a-191a.)

period for an abortion serves any interest of the state." (Pet.A. 17a.) The defendants' medical witnesses only testified about the waiting period that ordinarily occurs prior to in-hospital surgery, and did not relate this practice to the procedures involved in early abortions. (Pet.A. 17a.)

Defendants did not dispute the fact that the 24 hour waiting period can result in significantly longer delays. Plaintiff clinics perform abortions only two or three days a week. Thus, most women will actually be forced to wait two to four days, and for one week or more if they require general anesthesia, which is offered by one clinic only once a week. (Gotshall, J.A. 115a-116a.)

Defendants attempt to minimize the health risks created by this requirement by terming them "not critical" (D.Brief, p. 12.), and by ignoring the unrebutted proof that the wait could never be just 24 hours in Akron. The actual two to seven day delay resulting from the 24 hour waiting period requirement poses a serious health risk to women seeking abortion, because it multiplies morbidity and mortality risks (Tietze, J.A. 201a-202a; P.Ex. 75, p. 1/T.III, 212, 213.), and, as Dr. Crist testified, delays approaching a week can present a "real physical health hazard." (T.I, 70.)

Defendants totally ignore the serious mental health risks to some women (D.Brief, p. 12.), the possibility of which is noted by Judge Kennedy in her Sixth Circuit opinion. (Pet.A. 36a.) Dr. Crist testified that, in terms of psychological health, a 24 hour delay would be a very significant contribution to the "great emotional problem that women seeking abortions face," which is the "agony between making the decision and having the procedure done." (T.I, 70.) Imposing an inflexible waiting period causes increased anxiety, and constitutes callous disregard for the mental well-being of rape and incest victims. (Crist, J.A. 108a; Katz, T.IV, 127-128.) In some cases, this mandatory waiting period "will tip [a woman] to doing drastic things, such as self-abortion. . . ." (Crist, J.A. 108a.)

The mandated delay will also impose serious financial burdens on women seeking abortions. The district court found that the 24 hour waiting period makes abortions more expen-

sive by requiring the patient to make "two trips to the clinic instead of one,"[41] and by making the "cost of the procedure itself more expensive" by increasing the time the physician must spend with each patient. (Pet.A. 98a.) In addition to doubling the cost of travel, two trips will mean additional childcare costs and loss of pay from work. (Goldberger, J.A. 223a-224a.)

There was no evidence that women who seek abortions make hasty or ill-advised decisions, or that a waiting period enforced by criminal penalties will "actually benefit" women. (D.Brief, p. 47.)[42] On the other hand, plaintiffs demonstrated that the 24 hour waiting period would impose serious burdens on women seeking abortions.

SUMMARY OF ARGUMENT

I.

The criminal provisions severely limiting abortions enacted by the Akron City Council should be closely scrutinized by this Court because they have a significant impact on fundamental

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41 The issue of travel costs is serious, because as many as three out of every four patients at the plaintiff clinics are from outside the City of Akron. (Goldberger, J.A. 223a; Gotshall, T.I, 171.)

42 The one published study of the effects on abortion patients of a mandatory 48 hour waiting period was done in Tennessee in 1979-1980, prior to the injunction against the Tennessee law. Two surveys were made of some 400 women about the benefits and drawbacks of the waiting period. In the first survey, more than seven out of ten women were unable to name a single benefit derived from waiting, and six in ten pointed to one or more problems, including: extra expense; missed work or school (41% of all jobholders reported losing an average of $32.00 in pay because of the required second visit); and entering the second trimester. In the second survey one group of women was interviewed before and after the waiting period to see whether their attitudes toward it changed. The results showed that women realized fewer benefits and more problems from the wait than they had anticipated. Sixteen percent of the women had initially named an expected benefit from the wait; this dropped to 7% at the end of the required wait. (Lupfer & Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plan. Persp. 75 (1981), L.doc. 17, pp. 75-79.)

privacy rights protected by the Constitution. This Court held in *Roe v. Wade*, 410 U.S. 113, 153 (1973), that the right to decide whether or when to bear a child is a critical part of the constitutional right of privacy guaranteed by the due process clause of the Fourteenth Amendment. The decision in *Roe v. Wade* incorporating the standards of strict judicial scrutiny that apply when fundamental rights are impinged upon by government restrictions, was carefully followed by the Sixth Circuit Court of Appeals. Defendants did not meet their burden of showing that the regulations fulfill any compelling, or even less than compelling, state interests. In fact, two of the named defendants, the mayor of the City of Akron and the director of the health department, frankly admitted that there were no health or safety reasons for the restrictions.

II.

Sections 1870.06(B) and (C) of this municipal ordinance dictate what every doctor must tell every woman seeking an abortion, even in the case of medical emergencies. The ordinance mandates that doctors not only communicate medical risks, a requirement already established by state law, but also that doctors orally present welfare information, medical misinformation, and inflammatory and threatening statements designed to make a woman feel that abortion is murder. This puts a doctor in a "straitjacket" and burdens a woman's decision-making process. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 67 n.8 (1976). Furthermore, this section offends the very essence of the First Amendment because it forces the doctor to be the affirmative sponsor "of particular ethical or religious beliefs," which is something "we expect the state not to attempt in a society constitutionally committed to the ideal of individual liberty and freedom of choice." *Bellotti v. Baird*, 443 U.S. 622, 638 (1979).

III.

Section 1870.07 of the ordinance proscribes abortion until every woman has waited 24 hours from the time she has received the information dictated by § 1870.06(B) and (C).

Defendants did not show how this requirement, as applied to every woman, would actually promote a compelling, or even legitimate, state interest. The physical, emotional, and economic burdens that would be created by forcing every woman to make two trips, and inevitably wait more than 24 hours, were established.

IV.

Section 1870.03 requires that every abortion after twelve weeks take place in a hospital. Defendants did not prove that this regulation was narrowly tailored to promote maternal health interests. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976). At the time of trial, no second trimester abortions were available in hospitals in Akron. Furthermore, medical advances have made early second trimester abortions as safe in clinics as in hospitals and, in fact, the majority of early second trimester abortions in this country are performed in clinic facilities. The Sixth Circuit upheld § 1870.03 only because of this Court's summary affirmance in *Gary-Northwest Indiana Women's Services v. Orr,* 451 U.S. 934 (1981), a case involving a different statute and presented to this Court in a different procedural context.

V.

Section 1870.16 requires "humane and sanitary" disposal of fetal tissue. This requirement is void for vagueness under the due process clause of the Fourteenth Amendment. Defendants ask that this Court reconstruct the sentence by severing the word "humane," but to do so would clearly be contrary to legislative intent. *Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932).

VI.

Defendant City of Akron did not appeal the parental consent requirement, § 1870.05(B), to the Sixth Circuit Court of Appeals (Pet.A. 11a.) and for that reason should be precluded from appealing it to this Court. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 783 n.14 (1980). Furthermore,

the defendant-intervenors demonstrated no Article III standing requisite for appellate resolution. *Barry v. District of Columbia Board of Election and Ethics,* 580 F.2d 695 (D.C. Cir. 1978). They did not allege their daughters were sexually active, likely to become pregnant, or likely to seek an abortion. In addition, by the time of the Sixth Circuit appeal, both daughters were over age 15, and could not be affected by § 1870.05(B). *Roe v. Wade,* 410 U.S. at 127-129; *Craig v. Boren,* 429 U.S. 190, 192 (1976).

On the merits, § 1870.05(B) is unconstitutional because it gives parents or a court an effective veto over the minor's abortion. *H.L. v. Matheson,* 450 U.S. 398, 413-420 (1981) (Powell, J., concurring); *Bellotti v. Baird,* 428 U.S. 132 (1976). There is no way for mature or "best interests" minors to avoid parental consultation. As found by the district court (Pet.A. 93a.), the state juvenile court rules require both parents to be notified in every case. Because of its limited jurisdiction, juvenile court can order medical care only on a "best interests" standard after both parents have been adjudged neglectful; it cannot issue an adjudgment of maturity. As admitted by defendants, the Akron City Council has no authority to change jurisdictional rules of a state court. (D.Brief, p. 27.)

ARGUMENT

I.

CONSISTENT WITH PRINCIPLES OF JUDICIAL REVIEW, THE SIXTH CIRCUIT COURT OF APPEALS CORRECTLY APPLIED THIS COURT'S STANDARD FOR REVIEWING STATUTES WHICH IMPINGE UPON FUNDAMENTAL PRIVACY RIGHTS.

A. This Court Has Consistently Applied the Compelling State Interest Test Established in *Roe v. Wade.*

In *Roe v. Wade,* 410 U.S. 113, 153 (1973), this Court held that the "right to privacy, . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon

state action, . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." State interference with fundamental rights can be justified only by a "compelling state interest," and a showing that the regulations are narrowly drawn to serve those interests. *Id.* at 155.[43] Those state interests are (1) protecting the health of the pregnant woman, which does not become "compelling" until the second trimester of pregnancy and (2) protecting potential life, which does not become "compelling" until the fetus is considered by the physician to be viable. *Id.* at 162-163. Therefore,

> for the period of pregnancy prior to this 'compelling' point, the attending physician in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State. *Id.* at 163.

This Court has reaffirmed the *Roe* formulation in subsequent decisions; legislation which interferes directly with the abortion right is subject to strict scrutiny. Such laws are unconstitutional if they are not narrowly drawn to serve one of the compelling state interests set forth in *Roe*.[44] For instance, *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) struck down a statutory prohibition against the use of saline amniocentesis as an abortion technique after the first 12 weeks of pregnancy. This Court found that it did not

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[43] Regulations applicable to first trimester abortions are almost always invalid, since no compelling state interest exists at that stage. *Doe v. Bolton*, 410 U.S. 179, 195 (1973). *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) underscored that first trimester regulations which "restrict" abortion are permissible only if they insure the existence of the medical standards which underlie the finding in *Roe* of the safety of first trimester abortions.

[44] Laws impinging on fundamental rights are "presumptively unconstitutional." *Harris v. McRae*, 448 U.S. 297, 312 (1980). Once plaintiffs show the requisite degree of interference, defendants bear the burden of proving the law is narrowly tailored to further a compelling state interest. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 76-77 (1976); *Doe v. Bolton*, 410 U.S. at 195.

promote the state's interest in maternal health because abortion by that method was still safer than childbirth, and alternative abortion methods were not yet widely available. This Court further found that the requirement was not narrowly drawn, since other, more dangerous methods were not prohibited. *Id.* at 76-77. *See also Colautti v. Franklin,* 439 U.S. 379 (1979); *Carey v. Population Services International,* 431 U.S. 678, 686 (1977).[45]

As the Sixth Circuit correctly stated, the standard of review set forth by this Court requires a two-step analysis. If the regulation causes no legally significant impact on the abortion decision, it does not trigger strict scrutiny.[46] If it does impose a significant burden on first trimester abortions, the requirement is unconstitutional. For post-first trimester abortions, a regulation must be examined to determine whether it serves one of the two compelling state interests, and if it does, whether the burden is "undue," i.e. it is sufficiently narrowly drawn. (Pet.A. 10a.)[47]

This Court's rulings on the privacy rights of minors do not conflict with this standard. *Bellotti v. Baird,* 443 U.S. 622, 633

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45 Strict scrutiny analysis need not be employed when a regulation causes no significant burden. The *Danforth* Court upheld a record-keeping requirement because it had "no legally significant impact or consequence on the abortion decision." 428 U.S. at 80-81. Similarly, an informed consent requirement, which did not specify the content of the physicians' speech, was found not to interfere with the abortion decision. *Id.* at 77.

46 The decisions on public funding for abortions are not inconsistent with this analysis, since such restrictions, unlike laws which constitute "direct state interference with a protected activity," have been held to be "state encouragement of an alternative activity." *Maher v. Roe,* 432 U.S. 464, 474-475 (1977); *Harris v. McRae,* 448 U.S. 297, 314 (1980).

47 Defendants confuse "undue burden" with "burden." (D.Brief, p. 19.) This Court has used the phrase "undue burden" only to describe the ultimate constitutional determination following the application of one of the two possible standards of review. *See Maher v. Roe,* 432 U.S. at 470; *Carey v. Population Services International,* 431 U.S. at 686; *Bellotti v. Baird,* 428 U.S. 132, 147-148 (1976). Only the showing of a "burden" is necessary to invoke strict scrutiny. By using the phrase "undue burden," this Court has not suggested that the *Roe* framework has been replaced by a standardless balancing test.

(1979) recognized that "the status of minors under the law is unique in many respects." Thus, "the State has somewhat broader authority to regulate the activities of children than of adults," *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 74-75, because there are state interests at stake which are not present in the case of adults.[48]

B. Strict Scrutiny Provides a Clear Standard of Review.

Defendants ask this Court to reverse its established principle of utilizing strict scrutiny to analyze restrictive abortion laws and substitute a confusing and unmanageable ad hoc approach.[49] They advocate adoption of the standards of review used by the dissenting judge in the court of appeals and by the district court, which balanced the degree of interference with the abortion right against the importance of the interest asserted by the state. (D.Brief, p. 18, 21-22.) The problems that such an approach would create for lower courts and litigants are illustrated by the opposite results reached by those two judges as to the constitutionality of the 24 hour waiting period. The district court weighed the degree of interference caused by the waiting period against the asserted state interest and concluded that, although the requirement would create an increase in cost, this burden did not outweigh the "important" state interest in "insuring" that the woman consider her decision carefully. (Pet.A. 98a-99a.) Judge Kennedy, concurring with the majority, found the provision unconstitutionally overbroad because it posed "a grave risk to the mental health" of some women and created "such significant extra expense . . . as to

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[48] This Court has applied a similar two-step analysis in cases involving minors, inquiring whether or not a burden is imposed, and if so, applying a level of judicial scrutiny that requires the law to be narrowly drawn to further "significant" or "important" state interests, such as promoting parental involvement in the abortion decision. *H.L. v. Matheson,* 450 U.S. 398, 411-413 (1981); *Carey v. Population Services International,* 431 U.S. at 692-696; *Bellotti v. Baird,* 428 U.S. at 148.

[49] The clarity of this constitutional standard for abortion cases is reflected in the uniformity of the substantive results in the circuit courts of appeal which have considered challenges to restrictive abortion laws similar to the Akron ordinance. (See footnotes 57, 64, *infra.*)

unduly burden if not effectively prohibit," the abortion rights. (Pet.A. 36a.)

If this Court substituted a balancing test for strict scrutiny, lower courts would be left to speculate—and would inevitably disagree—on how to weigh an asserted state interest and how to evaluate the degree of the interference with the abortion decision.[50] Plaintiffs challenging such laws would never know the measure of proof necessary to satisfy a test for burdensomeness. The clarity and predictability of the present standard of review for abortion restrictions would be lost.

C. It is Essential For Federal Courts to Safeguard Constitutional Rights.

Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803), established the fundamental principle of judicial review, which holds that the Court, and not the legislature, is the final arbiter on matters of constitutional interpretation. This power of the Court "to say what the law is," *id.* at 177, allows the judiciary to act as a check on the legislative and executive branches of government, and to safeguard individual rights. The brief *amicus curiae* of the Solicitor General urges this Court to depart radically from this tradition, and to defer to state and local legislatures in matters involving abortion.[51] The Solicitor General suggests that this is appropriate because abortion is an area in which policy and constitutional principles "overlap," and because the right to choose abortion, like other privacy

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50 In *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 343 (1974) this Court rejected just such a case-by-case balancing with respect to interests protected by the First Amendment because such an "approach would lead to unpredictable results, and uncertain expectations, and it could render our duty to supervise the lower courts unmanageable." *Id.*

51 The Office of the Solicitor General made the claim in *Goldsboro Christian Schools, Inc. v. United States*, 436 F. Supp. 1314 (E.D. N.C. 1977), *cert. granted*, 50 U.S.L.W. 3278 (U.S. Oct. 13, 1981) (No. 81-1), that the Commissioner of Internal Revenue could not promote the fundamental national policy against racial discrimination. There, as here, the Solicitor General sought to reverse a long-standing tradition of enforcing fundamental rights in order to pursue a narrow political goal.

rights, is merely a "shadow" right, not explicitly protected by the Constitution. (S.G.Brief, pp. 11, 19.)

This Court has recognized that certain rights are so fundamental and "implicit in the concept of ordered liberty," as to be contained within more explicit guarantees of the Constitution. *Palko v. Connecticut,* 302 U.S. 319, 325 (1937). *Roe v. Wade,* 410 U.S. at 152-153, held that the right of privacy founded in the Fourteenth Amendment's concept of personal liberty, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The State's power to interfere with fundamental privacy rights is limited. *Paul v. Davis,* 424 U.S. 693, 713 (1976). The extent to which the abortion decision can be regulated, therefore, is not a matter of "choosing among competing policy alternatives" (S.G.Brief, p. 11), but rather one of protecting a constitutional right from infringement by political majorities.[52]

The Solicitor General argues that, because of the intensity of the abortion debate, abortion proponents and opponents should be left free to fight it out in the political arena. But it is precisely when popular sentiment runs highest that majoritarian institutions are the least reliable guarantors of individual rights. *See United States v. Carolene Products Company,* 304 U.S. 144, 152 n.4 (1938). As Justice Jackson eloquently stated in *West Virginia State Board of Education v. Barnette,* 319 U.S. 624, 638 (1943):

> "The very purpose of a Bill of Rights was to withdraw certain subjects from vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by

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52 The Solicitor General argues that the legislature has "superior fact-finding capability" and that the quality of the "product" is enhanced by leaving "the issue exposed . . . to the legislative process." (S.G.Brief, pp. 12-13.) The record in this case effectively rebuts this argument. It was undisputed that the Akron ordinance was designed to be a model "anti-abortion" ordinance. Its drafters were ignorant of the excellent record of the clinics. Furthermore, the issue was "exposed" at a secret hearing and voted on before all the council members were given a copy of the final text. The mayor of Akron refused to veto or sign this bill, stating that on issues such as this the courts are the place for "proper resolution." (See p. 5, *supra.*)

> the courts. One's right to life, liberty, . . . freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections."

The judicial standard suggested by the Solicitor General would effectively bar courts from carefully scrutinizing legislation having significant impact on fundamental rights. This shift would undercut *Roe*'s recognition of the fundamental nature of the abortion right, leaving it vulnerable to unreviewable legislative control. If deference is paid to state and local legislatures in the abortion context, there is no reason why other fundamental rights, such as the right to vote, should not be accorded the same treatment. Yet history teaches otherwise. *Brown v. Board of Education of Topeka,* (*Brown* I), 347 U.S. 483 (1954) which declared *de jure* school segregation unconstitutional, was met with passionate local resistance in many areas of the country. This Court responded by ordering school officials to comply with its ruling and declared "the vitality of these constitutional principles cannot be allowed to yield simply because of disagreement with them." *Brown v. Board of Education of Topeka,* (*Brown* II), 349 U.S. 294, 300 (1955). *See also Cooper v. Aaron,* 358 U.S. 1 (1958).[53]

Given that *Roe v. Wade* is the law of the land, as the Solicitor General concedes, it is the duty of this Court to uphold the constitutional rights guaranteed therein. Protection of individual liberties is never more important than when they are most imperiled.

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[53] As Justice Frankfurter stated:

> The Constitution is not the formulation of the merely personal views of members of the Court, nor can its authority be reduced to the claim that state officials are its controlling interpreters. Local customs, however hardened by time, are not decreed in heaven. Habits and feelings they engender may be counter-acted and moderated. Experience attests that such local habits and feelings will yield, gradually though this be, to law and education.

358 U.S. at 24-25 (Frankfurter, J., concurring)

II.

THE AKRON ORDINANCE RESTRICTIONS VIOLATE A WOMAN'S RIGHT TO PRIVACY WHICH ENCOMPASSES HER RIGHT TO CHOOSE ABORTION.

A. The Forced Speech Requirements of Sections 1870.06(B) and (C) Distort the Decision-Making Process and Unconstitutionally Burden the Abortion Decision.

Section 1870.06(B) of the Akron ordinance mandates that the "attending physician," under threat of criminal penalty, recite prescribed words to every woman seeking an abortion; § 1870.06(C) goes on to require the attending physician to inform every woman "of the particular risks associated with her own pregnancy and the abortion technique to be employed." (See Facts, pp. 15-20, *supra.*) These requirements unconstitutionally burden a woman's right to choose abortion by intruding into the physician-patient relationship, forcing the physician to say things "regardless of his own professional judgment as to the desirability of doing so" (Pet.A. 15a.), and preventing him from delegating certain parts of the counseling to others.

This Court noted in *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52, 67 (1976) that "[t]he decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." Section 1870.06(B) precludes the informed consent envisioned in *Danforth* by distorting the true nature and consequences of abortion. The ordinance destroys the flexible situation in which the patient's needs are taken into account, and forces the doctor to give false, misleading, and emotionally abusive information, designed to control the decision-making process by "skew[ing] the choice" against abortion. *See Planned Parenthood League of Massachusetts v. Bellotti,* 641 F.2d 1006, 1017 (1st Cir. 1981).[54]

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[54] Defendants concede the unconstitutionality of § 1870.06(B), (3), (4), and (5) (D.Brief, p. 37), and argue for severance, so that .06(B)(1), (2), (6),

The defects of § 1870.06(B) are obvious (See Facts, pp. 15-20, *supra.*); but .06(C) is equally objectionable. While in most cases the informed consent dialogue will include a discussion of the risks of abortion, continued pregnancy, and childbirth,[55] there are cases in which disclosure of some risks may be detrimental. The requirements preclude operation of "therapeutic privilege," which recognizes that in some cases, a physician need not disclose all information, either because the woman requests not to be told, or because he deems it to be in her best interests. (See Facts, p. 20 n.40, *supra.*)[56]

Because it is possible to create burdensome obstacles to abortion in the guise of promoting informed consent, this Court has recognized that such requirements must not be too rigid or specific, "confin[ing] the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 67 n.8.[57] Physicians must be allowed to

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and (7) can be saved. The question is whether the valid sections standing alone would "create a program quite different from the one the legislature actually adopted." *Sloan v. Lemon,* 413 U.S. 825, 834 (1973). *See also Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932). The district and circuit courts refused to rewrite § 1870.06(B) by severing some subsections. (Pet.A. 14a-15a, 96a.) Moreover, subsections (1), (2), (6), and (7) are no less impermissible. Subsections (1) and (2) would preclude doctors from performing menstrual extractions; subsections (6) and (7) would require the doctor to make certain representations about social welfare services which may not be true and which are not within the realm of medical expertise. (Facts, pp. 15-20, *supra.*)

55 The ordinance does not contemplate an evenhanded discussion of medical risks. Section 1870.06(C) requires that the physician discuss the risks of the woman's own pregnancy only in relationship to "the abortion technique to be employed," not in relation to the risks of continued pregnancy and childbirth.

56 The informed consent requirements must be followed even in cases of life-threatening emergencies. (See § 1870.12.)

57 Circuit courts have consistently agreed that statutes which attempt to dictate rigid informed consent requirements burden a woman's right to choose abortion. *Planned Parenthood League of Massachusetts v. Bellotti,* 641 F.2d 1006 (1st Cir. 1981); *Planned Parenthood Ass'n of Kansas City, Missouri v. Ashcroft,* 655 F.2d 848 (8th Cir. 1981); *Akron Center for*

exercise discretion, not because of any constitutional right to practice medicine, but because such restraints may make it impossible for the woman to exercise her right to choose whether or not to bear a child.

> The constitutional right vindicated in *Doe [v. Bolton,* 410 U.S 179 (1973)] was the right of a pregnant woman to decide whether or not to bear a child without unwarranted state interference. The statutory restrictions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely. . . . *Whalen v. Roe,* 429 U.S. 589, 604 n.33 (1977).

Because medical treatment, medical decision-making, and the patient-physician relationship are inherently complex, the law in Ohio already recognizes that the physician must have leeway to tailor the information necessary for informed consent.[58]

Reproductive Health v. City of Akron, (Pet.A. 1a-36a); *Women's Services, P.C. v. Thone,* 636 F.2d 206 (8th Cir. 1980) *vacated and remanded,* 452 U.S. 911 (1981); *Charles v. Carey,* 627 F.2d 772 (7th Cir. 1980).

58 Ohio Rev. Code Ann. § 2317.54 (Baldwin 1981), "Patients Informed Consent," entitles physicians to a legal presumption that informed consent has been obtained if its provisions are followed. (J.A. 329a-331a.) Under this statute, a legally valid consent to medical treatment need only set forth "in general terms the nature . . . of the procedure" and its "reasonably known risks." (J.A. 330a.) The original 1975 version of the law included a detailed form which had to be used in order to trigger the presumption. Ohio Rev. Code Ann. § 2317.54 (Page 1975). The 1977 amendment deleted the form in order to allow even greater physician flexibility. Ohio Rev. Code Ann. § 2317.54 (1977, deleting subparagraph D.) Because § 2317.54 creates a presumption in malpractice actions for doctors who comply with it, rather than mandating a specific procedure to be followed throughout the state, the Akron ordinance may not directly conflict with state law. *See In Re Decertification of Eastlake,* 66 Ohio St.2d 363, 422 N.E.2d 598 (1981). However, it is clear that the Ohio legislature's twice-affirmed policy of assuring physicians flexibility and respecting their discretion is diametrically opposed to the rigidity of the Akron ordinance. Finally, the ordinance is flatly inconsistent with Ohio Admin. Code § 3701-47-06, issued by the State Department of Health to govern second trimester abortions, stating that counseling of abortion patients shall be "non-judgmental, regardless of the

Sections 1870.06(B) and (C) require that the "attending physician" personally communicate to the woman the prescribed "facts."[59] If physicians were forced to personally do all counseling, fewer women could receive the strictly medical services which only doctors may provide. In Akron, physicians have delegated a substantial portion of the intensive, time-consuming informed consent and pregnancy counseling to professionally trained counselors. (Facts, p. 16, *supra*.) The district court found that prohibiting physicians from delegating a portion of the counseling responsibility increases costs. (Pet.A. 97a.) Given the limited numbers of doctors available to do abortions, this prohibition would restrict access to services. In addition, it prevents the physician from exercising judgment that delegation of such counseling would best serve the patient's needs.[60]

Furthermore, the attending physician requirement does not promote any interest in maternal health. Defendants failed to

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circumstances of the pregnancy, but shall not be forced on the woman." (P.Ex. 45, J.A. 299a.) *See also, Rhodes v. Doctors Hospital North*, 18 O.O.3d 391, 394 (Ct. App. Franklin Cty. 1980).

[59] The term "attending physician" used in § 1870.06 is not specifically defined, nor do the lower court opinions address whether this means the same physician who is to perform the abortion. The use of the modifying phrase "performing or inducing the abortion" in § 1870.06(D) could be read to imply that a physician different from the one doing the counseling will comply with § 1870.06(D)'s requirement. On the other hand, it defies common sense to think that one doctor will perform the duty referred to in § 1870.06(D), providing the pregnant woman with a duplicate copy of the signed consent form, after a different doctor has done the counseling. The district court posits an arrangement whereby a physician would counsel some women on the same day he performs abortions on other "previously counseled" women. The court, however, does not state whether the women were to have been previously counseled by the same physician. (Pet.A. 98a n.29.) Judge Kennedy speaks in terms of "a physician," implying that one physician may do the counseling and another may perform the procedure. (Pet.A. 35a-36a.) Defendants do not even claim that the state's interest in promoting maternal health would be furthered by having the same doctor perform the counseling and the abortion procedure.

[60] Plaintiffs' evidence showed that many doctors believe that specially trained counselors are better able to counsel the woman seeking an abortion than are doctors who may have no such training. (See Facts, pp. 16-17, *supra*.)

establish or even explain why doctor counseling would better serve the medical needs of women.[61] By contrast, plaintiffs presented abundant evidence of the high standard of medical care provided by plaintiff clinics, the reasonableness of physicians' judgment to delegate some counseling, and the fact that doctors made sure that the patients are giving a fully informed consent. (Facts, pp. 15-20, *supra*.)

Sections 1870.06(B) and (C) also violate the First Amendment. As the preamble to the ordinance makes clear (Pet.A. 115a, 116a.), the purpose of these requirements is to impress upon the woman the idea that the fertilized ovum is a human being from the moment of conception, and that abortion is murder.[62] The physician is compelled to make certain pronouncements for the state with which he might profoundly disagree. (Facts, p. 17, *supra*.) As this Court has observed, "where the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier for such message." *Wooley v. Maynard,* 430 U.S. 705, 717 (1977). *See also, West Virginia Board of Education v. Barnette,* 319 U.S. 624, 642 (1943).

The dictated counseling requirements would place anti-abortion speech in a preferred position to the neutral information now provided. Content-based regulation of speech requires the

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61 The testimony of the defendants' witnesses, in fact, was equivocal as to whether or not physicians should be allowed to delegate counseling duties. (Schmidt, T.X, 25.)

62 The requirement of § 1870.06(B)(3) that the physician tell the woman that "the unborn child is a human life" offends the physician's and woman's rights under the free exercise clause, in that it requires the physician to make, and the woman to hear what is, for many people, a statement of religious belief. The woman who may have made the abortion decision on the basis of her own moral or religious convictions is similarly forced to listen to words denigrating the legitimacy of her beliefs. Furthermore, parents must accompany their minor daughters under age 15 to the session dictated by §§ 1870.06(B) and (C). (See § 1870.06(A).) Parents who do not share the beliefs expressed in these sections would be forced to listen with their daughters to certain "truths" which may be contrary to their beliefs, and the beliefs and values they are trying to teach their children. *See Wisconsin v. Yoder,* 606 U.S. 205 (1972).

strictest scrutiny. *See Carey v. Brown,* 447 U.S. 455, 461-62 (1980). The impermissibility of this particular forced speech is underscored by this Court's admonition that the state cannot adopt one "theory of life" that overrides a woman's privacy right. *Roe v. Wade,* 410 U.S. at 162.

The First Amendment also protects a right to listen and receive information, *see Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.,* 425 U.S. 748, 756-57 (1976), and it is undisputed that this includes information about abortion. *Bigelow v. Virginia,* 421 U.S. 809, 821-22 (1975). The informed consent session, however, is not a public forum in which conflicting ideas freely compete. The woman listening to the required litany is in every sense a captive audience. If she does not go through the required counseling, she will be unable to obtain an abortion. Because she has no choice but to listen, her right not to receive information must be especially protected. *See Kovacs v. Cooper,* 336 U.S. 77, 86-87 (1949); *Public Utilities Commission v. Pollak,* 343 U.S. 451, 468 (1952), (Douglas, J., dissenting).

B. The Mandatory Waiting Period in Section 1870.07 Promotes No State Interest and Would Cause Serious Hardships.

Defendants concede that the mandatory waiting period imposes a "restriction" on a woman's "access to an abortion." (D.Brief, p. 47.) Regulations placing such legally significant obstacles on first trimester abortions are unconstitutional. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 61. Even as applied to second trimester abortions, any state interest in assuring the patient's informed consent is fully satisfied by Ohio's statutory and case law requiring disclosure of medical risks. (See Sec. IIA, p.34 n.58, *supra.*; *Siegal v. Mt. Sinai Hospital,* 62 Ohio App.2d 12, 403 N.E.2d 202 (1978).)

The waiting period imposes a medically unnecessary delay, creates risks to a woman's physical and psychological well-being, and significantly increases the cost of abortion. (See Facts, pp. 21-22, *supra*; L.doc. 8, p. 721.) The court of appeals held that the regulation was unconstitutional, not only because it

imposes a burden on abortions during the first trimester, but also because defendants failed to establish how an inflexible waiting period imposed on all women promotes "any interest of the state, much less a compelling interest." (Pet.A. 17a, *see also* Pet.A. 36a, Kennedy, J., concurring.)[63]

The 24 hour delay is not narrowly tailored. It applies to the woman obstetrician-gynecologist seeking an abortion, to the woman who has been fully counseled by her family physician, and to the woman for whom the delay would cause "such significant extra expense as to unduly burden, if not effectively prohibit, the decision." (Pet.A. 36a, Kennedy, J., concurring.) Section 1870.12 allows an exception only for physical health considerations; therefore the waiting period would apply "even where the delay would impose a grave risk to the mental health of the pregnant woman" (Pet.A. 36a, Kennedy, J., concurring), such as when the woman is a victim of rape or incest.

This statute creates an irrebuttable presumption that every woman needs to wait 24 hours after signing the consent form in order to make an informed and considered decision. The majority of women seeking abortions, however, have already made the personal and moral decision to have an abortion. The question of whether or not to bear a child is a life planning decision. For many women, it is not an issue which arises suddenly upon confirmation of pregnancy. Some women know they cannot feed or clothe any more children; others have decided they would not bear a severely deformed child.

Most women have already been counseled before going to the plaintiff clinics. Women who have not been counseled and need time to think are encouraged to wait. (Facts, pp. 15-16, *supra*.) A recent study found that, while the majority of women decide within 24 hours after receiving confirmation of

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63 Defendants did not meet their burden of proving that the requirement serves the asserted interest of protecting health. As the court of appeals found, the defendants' medical witnesses only testified about the waiting period that ordinarily occurs in general in-hospital surgical practice and did not relate these to the procedures involved in the early stages of pregnancy. (Pet.A. 17a.) The only favorable impact of the waiting period identified by defense witnesses was that it could provide a time to reflect. There was no evidence that women would "actually benefit." (D.Brief, p. 47.)

their pregnancy, some women wait as many as 75 days before deciding. (L.doc. 17, p. 76.)

The waiting period frequently exceeds 24 hours. This Court has recognized that "[t]ime, of course, is critical in abortion," and unnecessary delays are a legitimate concern to those needing abortions. *Doe v. Bolton*, 410 U.S. 179, 198 (1973). Seven circuit courts and eleven district courts[64] have concurred with the circuit opinion in this case and have either preliminarily or permanently enjoined waiting periods of 24 or 48 hours.[65]

The regulation also interferes with the woman's right to independent decision-making. *Whalen v. Roe*, 429 U.S. at 599-600.[66] The court of appeals found that the actual purpose

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64 See *Planned Parenthood League of Massachusetts v. Bellotti*, 641 F.2d 1006 (1st Cir. 1981); *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980); *Planned Parenthood Ass'n of Kansas City, Missouri, Inc. v. Ashcroft*, 655 F.2d 848 (8th Cir. 1981); *Women's Services, P.C. v. Thone*, 636 F.2d 206, (8th Cir. 1980) *vacated and remanded*, 452 U.S. 911 (1981); *Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979); *Friendship Medical Center v. Chicago Bd. of Health*, 505 F.2d 1141 (7th Cir. 1974); *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980); *Planned Parenthood of Rhode Island v. Roberts*, 530 F. Supp. 1136 (D.R.I. 1982); *Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980); *Women's Community Health Center, Inc. v. Cohen*, 477 F. Supp. 542 (D. Me. 1979); *Munson v. Meierhenry*, No. 80-3043 (D.S.D. Feb. 27, 1981); *Wolfe v. Stumbo*, No. C-80-0285-L(A) (W.D. Ken. Dec. 3, 1980); *Orr v. Knowles*, CV 81-0-301, CV 81-167 (D. Neb. May 30, 1981); *Eubanks v. Brown*, C-82-0360 L(A) (E.D.Ky. July 9, 1982) (two hours); *Glick v. List*, Civ. No. R-81-150-BRT (D. Nev. July 7, 1981); *Aware Woman Clinic, Inc. v. City of Cocoa Beach*, C.No. 77-361-Drl-Civ-4, (M.D. Fla., April 21, 1978); *Planned Parenthood of Memphis v. Alexander*, No. 78-2310 (W.D. Tenn. March 23, 1981) *appeal dis'd mem.*, 665 F.2d 1046 (6th Cir. 1980); *Mobile Women's Medical Clinic v. Bd. of Comm'rs*, 426 F. Supp. 331 (S.D. Ala. 1977).

65 These risks are significantly greater in the many states in which there are few abortion providers. For example, in North Dakota, where there is only one abortion provider, the additional expenses required by two trips or a two-night stay would have a "significant and substantial burden on a large number of women, especially on women in areas of western North Dakota who would have to travel over 400 miles to obtain an abortion." *Leigh v. Olson*, 497 F. Supp. 1340, 1347 (1980).

66 The woman's privacy interest in maintaining her anonymity is also jeopardized. Like the person who obtains contraceptives by mail to maximize confidentiality, the woman seeking an abortion has a strong interest in

of § 1870.07 is to require a "cooling off period during which second thoughts might come into play." (Pet.A.17a.) These "second thoughts" are not thoughts based on objective medical information, but rather "second thoughts" generated by the frightening misinformation dictated by § 1870.06(B). (D.Brief, p. 47.) The mandatory wait is intended to reinforce the value of the prescribed information, and also suggests to the woman that her decision to seek an abortion is not to be trusted. Rather than promoting any state interest, the waiting period is designed to interfere with the woman's right of privacy.

C. The Post-First Trimester Hospital Requirement of Section 1870.03 Unnecessarily Burdens Women and Does Not Further Any Legitimate Maternal Health Interests.

Section 1870.03 requires that every abortion after the first 12 weeks of pregnancy be performed in a hospital.[67] Plaintiffs demonstrated at the time of trial that there were no hospitals in Akron in which such abortions could be performed, and established the safety and widespread use of the D&E abortion technique for second trimester abortions in clinics. (See Facts, pp. 9-12, *supra.*) The court of appeals, while indicating that it found other cases striking down identical second trimester hospital restrictions "persuasive" (Pet.A.21a.), upheld § 1870.03 on the basis of this Court's summary affirmance in *Gary-Northwest Indiana Women's Services, Inc. v. Bowen,* 496 F. Supp. 894, (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr,* 451 U.S. 934 (1981).[68]

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keeping it private. *Carey v. Population Services International,* 431 U.S. at 691 (Powell, J., concurring.) Since a waiting period necessitates two trips, instead of one, a woman will miss an extra day of work or school, increasing the risk that her abortion will become known.

[67] Section 1870.03 replaced an earlier identical restriction that had been in effect since 1975. (Pet.A. 54a.) However, one clinic provider testified that they wanted to provide early second trimester D&E abortions, and would do so if there were no legal barriers. (Goldberger, T.II, 128.)

[68] As indicated in Petition for Certiorari, this case differs significantly from *Gary-Northwest* in at least three ways: First, the Indiana statute defines

In *Roe v. Wade,* 410 U.S. 113 (1973), this Court found that the state's interest in protecting maternal health becomes "compelling" at the end of the first trimester because, at that point, "mortality with abortion is equal to childbirth." *Id.* at 163. At that point in pregnancy, "a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." *Id.* at 163.

In *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 79, this Court examined a Missouri statute outlawing the use of saline amniocentesis after the first trimester of pregnancy and held that it was "unreasonable," "arbitrary," and "designed to inhibit, and [had] the effect of inhibiting, the vast majority of abortions after 12 weeks."[69] The Missouri statute was unconstitutional because, at the time of trial, saline amniocentesis was widely accepted in the medical community, abortions by other methods were not available in Missouri, and the prohibition increased risks to the women it was supposed to protect. *Id.* at 77-78.

Section 1870.03 has precisely the same effects. Today, second trimester D&E abortions performed in outpatient facilities are prevalent and widely accepted in the medical community. (Facts, pp. 9-12, *supra.*) Furthermore, because hospital facilities for second trimester abortions are not available in Akron, the prohibition of § 1870.03 increases costs and health risks for women who must either travel or forego an abortion. This

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"hospital" to include ambulatory outpatient centers; second, there was no full trial in Gary-Northwest—the questions presented in the jurisdictional statement were procedural, not substantive; and third, the district court in *Gary-Northwest* found several evidentiary failures not present in this case. (496 F. Supp. at 903.) Because of these differences, *Gary-Northwest* is not binding precedent. See *Tully v. Griffin, Inc.,* 429 U.S. 68, 74-75 (1976); *Edelman v. Jordan,* 415 U.S. 651, 671 (1974).

[69] This Court has recognized that state regulations which limit access to the means of effectuating the exercise of privacy decisions are subject to the same scrutiny as are laws which would prohibit the decision entirely. *Carey v. Population Services International,* 431 U.S. at 688.

prohibition not only fails to promote maternal health, but also significantly increases risks to maternal health and life.[70]

Defendants completely failed to meet their burden of showing that § 1870.03 is narrowly tailored to promote maternal health. When § 1870.03 was passed by the City Council, hospitals in Akron were unavailable to do second trimester abortions.[71] It was incumbent on defendants to show that second trimester hospital abortions were available at the time of trial, and they failed to do so. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 78 n.12, 92 (Stewart, J. and Powell, J., concurring), 102 (Stevens, J., concurring). The sole evidence offered by defendants to justify § 1870.03 was that the American College of Obstetricians and Gynecologists (ACOG) had not changed its 1973 recommendation that second trimester abortions be performed only in hospitals. (Pet.A.19a.) Subsequent to the trial, the ACOG changed its standard and now recognizes the safety of out-patient second trimester abortion services. (Appendix B to this

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70 In *Planned Parenthood Ass'n of Kansas City v. Ashcroft,* 664 F.2d 687 (8th Cir. 1981), the court struck down a Missouri statute identical to § 1870.03, finding out-of-hospital second trimester D&E abortions no more dangerous to maternal health than hospital procedures. *Id.* at 690. In *Margaret S. v. Edwards,* 488 F. Supp. 181 (E.D. La. 1980) the court struck down the second trimester regulation because no hospitals in Louisiana were available for any abortions, and because the law would "effectively halt the performance of post-first trimester abortions in Louisiana." The court found that "[t]his result endangers maternal health by forcing a woman . . . to select from a range of alternatives more dangerous to maternal health than performance of a post-first trimester abortion in a clinic where such abortions are now safely performed." *Id.* at 192, 193.

71 The Sixth Circuit found that there were only two hospitals in Akron in which second trimester abortions were performed, and that in the year before trial only nine such abortions had been performed. (Pet.A. 19a.) Out of these nine, one hospital listed two out of three as "therapeutic" (P.Ex. 47, J.A. 302a.); of the six performed at the other hospital, five were for the removal of dead fetuses. (P.Ex. 46, J.A. 300a; Ohio Admin. Code § 3701-47-01(E), P.Ex. 45, T. 22.) During that same period of time, approximately 600 women needing second trimester abortions had to be referred to Cleveland or Michigan. (Pet.A. 19a.) There was unrebutted testimony that, at the time of trial in 1978, no second trimester abortions were available in any Akron hospital. (Gotshall, J.A. 112a-113a.)

Brief.) Therefore, defendants have presented absolutely no evidence that an in-hospital requirement for all second trimester abortions promotes health interests; in fact, it burdens all women needing such abortions and effectively vetoes the choice of some.

D. The Fetal Disposal Requirement of Section 1870.16 is Unconstitutionally Vague.

Both the district court and the court of appeals found § 1870.16, which requires that fetal remains be disposed of in a "humane" manner, to be unconstitutionally vague. Like the statute stricken in *Colautti v. Franklin,* 439 U.S. 379 (1979), § 1870.16 forces physicians to speculate on the meanings of ambiguous language at the risk of criminal prosecution. "Humane" is a word which, as the district court found, "can evoke a totally different understanding in each individual listener." (Pet.A.103a.) "It therefore presents serious problems of notice, discriminatory application, and chilling effect on the exercise of constitutional rights." *Colautti v. Franklin,* 439 U.S. at 394.

Use of the word "humane" to describe the disposal of fetal tissue suggests that such tissue should be treated as though it were a deceased human being. This requirement is unrelated to any legitimate state interest.[72]

Defendants have never proffered a meaning for "humane," either to this Court or to the court of appeals. (D.Brief, pp. 48-49.) Instead, they rely on *Planned Parenthood Association v. Fitzpatrick,* 401 F. Supp. 554 (E.D.Pa. 1975) *aff'd mem. on*

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72 A doctor who removes a fetus which has already died inside the uterus, a procedure which is exempted from the definition of "abortion" in § 1870.01(A), has no obligation to handle the tissue "humanely." Similarly, disposal of the fetal products of a spontaneous abortion are unregulated by the Akron ordinance. The state law, cited by defendants (D.Brief, p. 48.), which requires "humane" disposal of the "fetus," Ohio Admin. Code § 3701-47.05, contains no language limiting its scope to induced abortions. It is limited, however, by the definition of "fetus" in § 3701-47-01(E), to products of conception removed after the fourteenth week of pregnancy. Section 1870.16 thus functions solely to impose a penalty on doctors who perform abortions.

other grounds sub nom. Franklin v. Fitzpatrick, 428 U.S. 901 (1976),[73] in which the district court upheld a Pennsylvania law requiring promulgation of regulations for the "humane" disposal of fetal tissue. The provision at issue was not a criminal law but "merely an enabling statute" 401 F. Supp. at 573. Standards for vagueness are less stringently applied to laws such as enabling statutes than to criminal statutes. *Winters v. New York,* 333 U.S. 507, 515 (1948).

The district court, in *Fitzpatrick,* found that the Pennsylvania disposal law was grounded in the state's interest in protecting public health.[74] The Akron ordinance, by contrast, mandates disposal in a "humane *and* sanitary" manner, thus requiring physicians to use methods which are more than sanitary in order to escape a criminal penalty.[75] The Sixth Circuit correctly found that "[t]he possibility that the language of § 1870.16 might be construed to mandate some sort of 'decent burial' of an embryo at the earliest stages of formation is too real to be overlooked." (Pet.A. p. 24a.)

The defendants attempt to redeem § 1870.16 by arguing that the word "humane" should be excised. The severability clause in § 1870.19 does not suggest that words within a sentence can be severed. Nor is there any reason to believe that the City Council would have enacted § 1870.16 without including the

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[73] The only question presented on appeal to this Court was the constitutionality of the "informed consent" provisions of the statute. 44 U.S.L.W. 3375 (Dec. 23, 1975). Thus the summary affirmance did not include the lower court's ruling as to fetal disposal.

[74] The defendants attempt to import the legislative intent behind the Pennsylvania law to Akron, by citing Pennsylvania's asserted desire "to preclude the mindless dumping of aborted fetuses on to garbage piles," *Planned Parenthood Ass'n v. Fitzpatrick,* 401 F. Supp. at 573, as establishing the intent of the Akron City Council. (D.Brief, at 48.) That phrase, however, appears in *Fitzpatrick* as one of the examples given by the state of "obvious public health considerations regarding sanitation [and] disease prevention." *Id.* at 573. Akron's interest in public health is served by the specific "sanitary" disposal language in § 1870.16.

[75] Canons of construction require that a statute be interpreted so as not to render phrases redundant or superfluous. *Colautti v. Franklin,* 439 U.S. at 392.

word "humane". *Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932). Fetal tissue is referred to in § 1870.16 as "the unborn child," a phrase which is repeated throughout the ordinance. The concepts of "humane" disposal and "unborn child" are entangled in the legislative intent, making it impossible to repair the unconstitutionality of this section by judicial editing.

III.

SECTION 1870.05(B) IS NOT PROPERLY BEFORE THIS COURT BECAUSE NO PARTY WITH ARTICLE III STANDING APPEALED TO THE COURT OF APPEALS.

The district court held that § 1870.05(B), requiring parental consent for a minor's abortion, was unconstitutional. (Pet.A. 92a.) Defendant City of Akron did not appeal that ruling to the court of appeals. (Pet.A. 11a.) The City is hence foreclosed from obtaining review of that question in this Court (*United States v. Santana,* 427 U.S. 38, 41 n.2 (1976); *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 146 n.2 (1970); *California v. Taylor,* 353 U.S. 553, 556 n.2 (1957)), despite the fact that the issue was raised in the Sixth Circuit by the defendant-intervenors. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 783 n.14 (1980).

In *O'Bannon,* this Court was faced with the same question: whether a defendant who acquiesces in an adverse ruling at the district court level, which its co-defendant appeals to the court of appeals, can then raise the issue in the Supreme Court. This Court held that the defendant's waiver of that issue in the court of appeals precluded Supreme Court review, even though its co-defendant, who did not petition for certiorari, raised the question below. *Id.* at 783 n.14.

As in *O'Bannon,* the Court should not allow the City of Akron to invoke the defendant-intervenor's appeal to cure its waiver on the parental consent issue, particularly since the

intervenors had no Article III standing necessary to prosecute an independent appeal in the Sixth Circuit.[76]

The district court, pursuant to Fed.R.Civ.P. 24(b)(2), permitted the intervenors to participate as defendants "solely in their individual capacity as parents of unmarried minor daughters of childbearing age." (Pet.A. 45a.) While a party seeking to intervene in the district court need not possess the standing necessary to initiate the lawsuit, *Trbovich v. United Mine Workers of America,* 404 U.S. 528 (1972), an intervenor "does not automatically have the ability to appeal a decision which all other parties have decided not to appeal." *United States v. Imperial Irrigation District,* 559 F.2d 509, 521 (9th Cir. 1977), *rev'd on other grounds sub nom. Bryant v. Yellen,* 447 U.S. 352 (1980). Here, because the City "acquiesced in the judgment against them, [the intervenors had to] demonstrate such a stake in the outcome of an appeal that a live Article III case or controversy remains for appellate resolution." *Legal Aid Society of Alameda County v. Brennan,* 608 F.2d 1319, 1328 n.9 (9th Cir. 1979), *cert. denied,* 447 U.S. 921 (1980). The intervenors did not attempt to demonstrate their standing in their own right; any effort to do so would have failed resoundingly.

None of the intervenors' daughters were then pregnant. *See Roe v. Wade,* 410 U.S. at 127-129. The intervenors did not allege that their daughters were sexually active, likely to become pregnant, or that if their daughters were to become pregnant, they would seek an abortion in Akron. The speculative chain of events which must be envisioned here can hardly satisfy the minimum Article III requirement that the litigant show "an injury to himself that is likely to be redressed by a favorable decision." *Simon v. Eastern Kentucky Welfare Rights Organization,* 426 U.S. 26, 38 (1976).[77] Furthermore, at

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[76] Although plaintiffs did not question the standing of the intervenors in the Sixth Circuit, it is well-settled that the question of standing cannot be waived, and Article III limits judicial power to justiciable controversies. *Doremus v. Bd. of Educ. of the Borough of Hawthorne,* 342 U.S. 429 (1952).

[77] In *Fisher v. Tucson School Dist. No. One,* 625 F.2d 834, 837 (9th Cir. 1980), and *Barry v. Dist. of Columbia Board of Elections and Ethics,* 580 F.2d 695 (D.C. Cir. 1978), the courts refused to hear appeals brought by intervenor-appellants who lacked Article III standing.

the time of trial in 1978, the two intervenors each had 14 year old daughters (Black, T.VI, 153; Seguin, T.VII, 49). While they testified that they had younger children, they did not specify their age or sex. Since the two minors were over age 15 when this case was before the circuit court, their claims were moot. *Craig v. Boren*, 429 U.S. 190, 192 (1976). Because defendants did not appeal to the circuit court, and the intervenors lacked standing, this Court should dismiss defendants' Petition for Certiorari on § 1870.05(B) as improvidently granted.

IV.

THE PARENTAL CONSENT REQUIREMENT IS UNCONSTITUTIONAL BECAUSE IT PROVIDES NO JUDICIAL ALTERNATIVE FOR MATURE OR BEST INTERESTS MINORS.

If this Court reaches the merits of § 1870.05(B), it must affirm the ruling that this section is unconstitutional:

> [A] State may not validly require notice to parents in all cases, without providing an independent decisionmaker to whom a pregnant minor can have recourse if she believes that she is mature enough to make the abortion decision independently or that notification otherwise would not be in her best interests.

H.L. v. Matheson, 450 U.S. 398, 420 (1981) (Powell, J., concurring); *see also Bellotti v. Baird*, 443 U.S. 622, 642-48 (1979).

Section 1870.05(B) prohibits physicians[78] from providing abortions to girls under age 15 unless the physician first

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[78] The district court found that plaintiff physician Bliss had standing to raise the claims of his minor patients under age 15. (Pet.A. 56a.) *Accord; Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Bellotti v. Baird*, 443 U.S. at 627 n.5 (1979) (upholding the standing of plaintiff physician to raise constitutional claims of the statute "as applied to all pregnant minors who might be affected by it. We accept that the rights of this entire category of minors [immature and mature] properly were subject to adjudication."). In the present case, where the lower courts denied all requests to proceed pseudonymously (R.15, R.26, R.31, R.32; Pet.A.

obtains the written consent of a parent or an order from a court "that the abortion should be performed." The district court struck down this statute because both the parents and the court could arbitrarily veto a minor's abortion. (Pet.A. 92a, *aff'd.*, Pet.A. 12a.)[79]

Although § 1870.05(B) states that "a court having jurisdiction over her" might order "that the abortion be performed," it does not specify which court, the procedures to be followed, or the ground upon which such an order might be based.[80]

Defendants suggest that the juvenile court of Ohio is the "court having jurisdiction over [the minor]." (D.Brief p. 4, 26.) However, the juvenile court is a forum of strictly limited jurisdiction. The only circumstance in which the juvenile court can authorize non-emergency medical treatment is upon a finding of parental neglect.[81] Ohio Rev. Code Ann. § 2151.03 (J.A. 325a) defines a neglected child as one

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22a), the physician is not only the "best available proponent," *Singleton v. Wulff*, 428 U.S. 106, 116 (1976), but considering all the circumstances, an immature, "best interests" pregnant plaintiff is "in all practical terms impossible." *Id.*, 428 U.S. at 126 (Powell, J., dissenting). The plaintiff clinics, who may be held both civilly and criminally liable for failing to comply with the ordinance, also have standing to raise the claims of their patients. *Flast v. Cohen*, 392 U.S. 83, 101 (1968); *Eisenstadt v. Baird*, 405 U.S. 438, 443-445 (1972); *Carey v. Population Services International*, 431 U.S. 678, 682-684 (1977).

79 In striking down § 1870.05(A), a parental notice provision not before this Court, that contains the same court bypass as § 1870.05(B), the district court held there was no judicial alternative because state juvenile court rules require parents be notified in every case. (Pet.A. 93a.) *See also, In re Corey*, 145 Ohio St. 413, 61 N.E.2d, 892 (1945).

80 Defendants erroneously assert (D.Brief, p. 26) that plaintiffs did not raise the inadequacy of the court alternative. The issue was argued to the trial court (R.196, p. 7-9), which held that the judicial alternative for parental notice was unconstitutional because of mandatory notice in the juvenile court procedure. (Pet.A. 93a.) Furthermore, subsequent to this Court's decision in *Bellotti v. Baird*, 443 U.S. 622 (1979), plaintiffs filed two post-trial supplementary briefs on this issue. (R. 247, filed July 25, 1979; R. 249, filed August 15, 1979.)

81 Ohio Rev. Code Ann. § 2151.23 (J.A. 326a) defines the jurisdiction of the juvenile court to hear petitions: "(A) (1) concerning any child who on

> [w]hose parents, guardian or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being.

Perhaps to get around the problem of the limited jurisdiction of the juvenile court, defendants assert that the court is available only where "the parents or guardian are either unavailable or refuse consent." (D.Brief, p. 4.) This interpretation is contrary to the plain language of Section 1870.05(B), which provides for a court bypass as an alternative to parental consent, not as a means of appealing a parent's refusal. Defendants do not say what happens to those minors whose best interests require that one or both parents not be informed, nor to those minors who are mature; for these two groups there is no court alternative.

Defendants assert that this statute is directed only "at minors unable to give an effective consent" (D.Brief, p. 25.),[82] ignoring the extensive evidence by both plaintiffs' and defendants' witnesses, as well as the district court findings (Pet.A. 93a), that there are Akron minors under 15 who are mature enough to make a well informed decision, and that there are some whose best interests require that their parents not be involved. (See *Facts*, pp. 13-14, *infra*.)

There are other constitutional infirmities inherent in the juvenile court as well:[83] juvenile courts have no power to render

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or about the date specified in the complaint is alleged to be a juvenile traffic offender, delinquent, unruly, abused, *neglected*, or dependent." (Emphasis added) Both parents are automatically notified when a juvenile court proceeding is begun. Ohio Rev. Code Ann. § 2151.28 (Pet.A. 93a). If a doctor is not willing to certify an emergency as defined by § 1870.12, the minor who has serious health problems may seek an order for emergency medical care from the juvenile court; however, even under this procedure, notice to the parents is mandated. Ohio Rev. Code Ann. § 2151.33 (J.A. 328a-329a).

82 A state may not, in the abortion context, enact a statute that precludes "the opportunity for case by case evaluations of the maturity of pregnant minors." *Bellotti v. Baird*, 443 U.S. 622, 643 n.23 (1979).

83 For authority in asserting additional grounds in support of the judgment striking down § 1870.05(B), *see Toll v. Moreno*, 50 U.S.L.W. 4880 n.26 (U.S. June 28, 1982); *Dandridge v. Williams*, 397 U.S. 471, 475 n.6 (1970).

an adjudgment of maturity; the court may apply only a "best interest" standard with the parents charged with neglect;[84] the Ohio juvenile court provisions do not assure expeditious consideration of minors' petitions for abortions, nor that they be confidential.

The evidence in the record shows that nearly all minors under age 15 are accompanied by at least one parent, and the few who are not are the victims of tragic or desperate family situations. There are parents who will never consent to an abortion regardless of health or life concerns and will "obstruct both an abortion and . . . access to court." *Bellotti v. Baird*, 443 U.S. at 647.

For this reason, this Court has consistently held that if a state seeks to encourage parental involvement in the abortion decision, it must provide some effective means by which minors who are mature, or whose best interests would be threatened by parental involvement, may obtain an abortion without parental notification or consent.

CONCLUSION

This Court should dismiss as improvidently granted defendants' petition for a writ of certiorari on Section 1870.05(B) or, in the alternative, affirm the judgment of the court of appeals on Section 1870.05(B); affirm the judgment of the court of appeals on Sections 1870.06(B) and (C), 1870.07, and 1870.16; and vacate the judgment of the court of appeals on Section 1870.03, and remand the issue to the court of appeals for further proceedings.

Dated: New York, N.Y.
August 27, 1982

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[84] Although Judge Kennedy in the Sixth Circuit Court of Appeals states that § 1870.05(B) may be constitutional if "the order from a court having jurisdiction was based, as it constitutionally must be," (Pet.A. 33a) on a maturity inquiry, it is clear that Ohio juvenile court has no jurisdiction to make this type of judgment. Further, defendants admit that the City of Akron could not modify the state juvenile court statute since to do so would be unconstitutional under the Ohio constitution. (D.Brief, p. 27.)

Respectfully submitted,

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328
Counsel of Record

JANET BENSHOOF
SUZANNE M. LYNN
NAN D. HUNTER
American Civil Liberties Union
Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

Attorneys for Respondents and Cross-Petitioners

Of Counsel:

SYLVIA LAW
40 Washington Square South
New York, New York 10012
(212) 598-7642

DEBORAH J. STAVILE
125 Broad Street
New York, New York 10004
(212) 558-4000

LOUIS A. JACOBS
1659 North High Street
Columbus, Ohio 43210
(614) 422-6821

GORDON BEGGS
1223 West Sixth Street
Cleveland, Ohio 44113
(216) 781-6276

APPENDICES

APPENDIX A

For the convenience of the Court, plaintiffs provide this list and brief description of their expert medical and theological witnesses.*

The medical witnesses included:

Dr. Robert T. Bliss, a practicing physician who provides abortion services in Akron and specializes in family planning. Dr. Bliss testified as to the difficulties he would face as a physician if compelled to comply with the informed consent and waiting period requirements of the Akron ordinance.

Dr. Charles V. Bowen, a practicing physician, specializing in obstetrics and gynecology. At the time of trial he was Secretary of the Summit County Medical Society, a former Chairman and current member of the Maternal and Infant Health Committee, and a member of the Akron Obstetrical and Gynecological Society. Dr. Bowen described his visits to the three abortion clinics in Akron and testified that there was no medical need for an ordinance.

Dr. Robert Dale Crist, Associate Professor of Obstetrics and Gynecology and Assistant Professor of Biochemistry, University of Kansas, School of Medicine. Dr. Crist is board certified and maintains a practice in obstetrics and gynecology. He is a member of the Task Force on Adolescent Pregnancy, American College of Obstetricians and Gynecologists. Dr. Crist described various abortion techniques and their risk factors in both the first and second trimesters of pregnancy. He further testified as to the medical and psychological risks caused by a waiting period and the adverse effects on minors of requiring parental notice or consent prior to abortion.

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* Plaintiffs do not list here approximately fifteen other witnesses. These witnesses included: abortion clinic personnel; Planned Parenthood officials; two Akron City Council members; state and county health and welfare officials; hospital medical records administrators; one of the drafters of the Akron ordinance; and clergy members.

Dr. Henry David, Director of the Transnational Family Research Institute, Bethesda, Maryland, and Associate Clinical Professor of Psychology, University of Maryland Medical School. Dr. David has a Ph.D. in clinical psychology and is a certified psychologist. He has been consultant to the World Health Organization and the National Academy of Sciences Institute of Medicine. He has written several books and testified concerning the positive psychological effects women experience after having an abortion.

Dr. Felix P. Heald, Professor of Pediatrics, University of Maryland School of Medicine, and Director of the Division of Adolescent Medicine, University Hospital. Dr. Heald is board certified in pediatrics with a subspecialty in adolescent medicine. He has had extensive experience in the areas of teenage sexuality and pregnancy and has served as a consultant for the United States Department of Health and Human Services. Dr. Heald testified about the medical and psychological problems of pregnant teenagers. He further testified as to the negative effects of requiring that certain information be given to pregnant teenagers during counseling.

Dr. Adele Hofmann, Director of the Adolescent Medical Unit, New York University Medical Center, Bellevue Hospital, and Associate Professor of Pediatrics, New York University Medical School. Dr. Hofmann is board certified in pediatrics with a subspecialty in adolescent medicine. She is the author of numerous books and articles on adolescent health care, sexuality and counseling and has twice been invited to testify before Senate committees. Dr. Hofmann testified concerning the medical and psychological problems faced by pregnant teenagers. She also testified about the negative effects on pregnant teenagers of the Akron parental notice and consent requirements, as well as the sections regulating informed consent.

Dr. Jay Katz, Adjunct Professor of Psychiatry and Law, Yale Law School, and supervisor of psychoanalysts at the Western Institute for Psychoanalysis. Dr. Katz is board certified in psychiatry, has been elected to the Institute of Medicine, is a Fellow of the American Psychiatric Association, and is

Co-Chairman of the Connecticut Bar Association Committee on the Legal Profession. He is the author of several books and numerous articles on psychoanalysis and law, family law, human experimentation and law and medicine. He was a consultant on a United States Department of Health, Education and Welfare study concerning informed consent and human experimentation, and has testified as an expert witness in numerous cases involving medical-legal matters. Dr. Katz described the concept of informed consent in medicine and law and testified that the informed consent requirements of the Akron ordinance would have an adverse impact on the physician/patient relationship.

Dr. Carl William Keck, Director of Health, City of Akron. Dr. Keck testified about a report he prepared and submitted to the Akron City Council during hearings on Akron City Ordinance 1870. The report provided statistical evidence indicating that there was no health related need to regulate Akron's abortion facilities.

Dr. Thomas Kerenyi, Chief of Obstetrics and Gynecology, Mt. Sinai Hospital, and Professor of Obstetrics and Gynecology, Mt. Sinai School of Medicine. He has written over 40 publications in the area of human reproduction. Dr. Kerenyi testified about second trimester abortion, premature labor, the difficulty in determining viability, and the information he provides patients concerning fetal characteristics.

Dr. Christopher Tietze, Senior Fellow in the Center for Policy Research of the Population Council. He has been a consultant for the World Health Organization, a member of the Advisory Committee on Obstetrics and Gynecology to the United States Food and Drug Administration, and has been Chairman of the Steering Committee of the World Health Organization's Task Force on Sequelae and Complications of Induced Abortions since 1973. Dr. Tietze has published over 200 articles in the area of human fertility and its regulation, including more than 100 articles on abortion. His work has been cited to by this Court in *Roe v. Wade.* Dr. Tietze testified about studies conducted in the United States and Great Britain

on the risks of mortality and morbidity associated with abortion.

The theological witnesses included:

Dr. Walter Weist, an ordained Presbyterian minister and member of the faculty of Pittsburgh Theological Seminary. He has a Ph.D. in Theology and teaches courses on theology and on ethical issues in law and human sexuality. Dr. Weist testified that defining an "unborn child" as a human life from the moment of conception is a religious view.

APPENDIX B

STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES

5th Edition, 1982

Published by the AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS.

GYNECOLOGY - AMBULATORY CARE - PAGE 16

Abortion

Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting. Physicians performing abortions in their offices should provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication. Clinics and free-standing ambulatory facilities should have written agreements with nearby hospitals for the transfer of patients requiring treatment for emergency complications of abortion procedures.

Generally, abortions in the physician's office or outpatient clinic should be limited to 14 weeks from the first day of the last menstrual period. In a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility, abortions should be limited to 18 weeks from the last menstrual period. Prior to abortion, the woman should have access to special counseling that explores options for the management of an unwanted pregnancy, examines the risks, and allows sufficient time for reflection prior to making an informed decision. If counseling has been provided elsewhere, the physician performing the abortion should verify that the counseling has taken place.

In addition to the usual and customary history, physical examination, and indicated laboratory procedures, an Rh fac-

tor determination should be made. Aspirated tissue should be examined to ensure the presence of villi or fetal parts prior to the patient's release from the facility. If villi or fetal parts are not identified with certainty, the tissue specimen must be sent for further pathologic examination, and the patient must be alerted to the possibility of an ectopic pregnancy.

Rh immune globulin must be administered to every unsensitized Rh(D) negative woman who has an abortion.

APPENDIX C

AMERICAN PUBLIC HEALTH ASSOCIATION

Resolution

Adopted

November, 1979

THE RIGHT TO SECOND TRIMESTER ABORTION

The American Public Health Association,

Recognizing that it has consistently advocated women's right to abortion (Resolution #7626), physicians' freedom to perform abortion (#6718); and has urged the removal of state statutes restricting abortion (#7118), and supported the inclusion of abortion in public funding (#7025);

Acknowledging that although the United States Supreme Court has recognized women's right to abortion to the point of viability in the 1973 *Roe vs. Wade* decision, anti-abortion groups are harassing women seeking abortions, as well as abortion providers across the country, and are creating immense pressure on physicians who perform later abortion procedures; and

Further while acknowledging the greater safety of first trimester abortions, it is recognized that women who seek later termination abortions are often treated disrespectfully by hospital personnel who oppose abortion; and

Noting that only 9 percent of legal abortions are performed in the second trimester of pregnancy; that greater use of the dilatation and evacuation procedure make it possible to perform the vast majority of second trimester abortions during or prior to the 16th week after the last menstrual period (LMP), which is the 14th week of pregnancy; and that most women who seek abortions after the 16th week LMP are facing severe social and health circumstances, such as pregnancy at a very young age or involving a fetus with known serious congenital abnormalities or disease; and

Noting that through curtailment of funding at both the federal and state levels, poor women have seen their right to abortion erode; therefore

1. Renews its support of women's right to abortion up to and to the point of viability.

2. Urges strong opposition to local state proposed or enacted ordinances which present misleading and non-factual information which may be perceived to frighten and harass women who choose abortion and health care providers performing these abortions.

3. Urges endorsement of educational programs which train physicians and health care personnel to provide safe later abortion techniques of Dilatation and Evacuation and saline infusion.

4. Urges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certifications.

APPENDIX D

NATIONAL MEDICAL COMMITTEE OF THE PLANNED PARENTHOOD FEDERATION OF AMERICA.

STANDARDS FOR EARLY MIDTRIMESTER ABORTION IN PLANNED PARENTHOOD AFFILIATES

Revised March, 1980

INTRODUCTION

Several studies have shown that, in programs conducted by experienced physicians, there are both increased safety and decreased costs of abortion with early second trimester dilatation and evacuation when compared with any other technique at this gestational stage, and with instillation techniques in the mid to late second trimester. The National Medical Committee, therefore, holds that selected Planned Parenthood Affiliates may provide abortion by D&E through 18 menstrual weeks, if outpatient second trimester procedures are permitted by state law.

Planned Parenthood Affiliates interested in adding a D&E program must have demonstrated competence in, and adequate facilities and equipment for, the performance of first trimester abortion. The D&E service must be planned in accordance with the protocol outlined in Approval of New Services (Part One—S&G, Section XV, Abortion), which includes the development of an affiliate manual of policies and procedures for D&E. These Standards are intended for such Affiliate programs.

It is expected that D&E services in Planned Parenthood Affiliate centers will utilize laminaria tents for dilatation inserted prior to the evacuation procedure, and, generally, mild analgesia and local anesthesia. Prophylactic antibiotics are appropriate when laminaria are used.

It is preferable for D&E programs using general anesthesia and heavy sedation to be conducted at local hospitals. How-

ever, such D&E programs may be undertaken in approved Affiliate clinics if (a) all of the Standards outlined here are observed, (b) provision is made for a certified anesthetist or anesthesiologist to participate in each procedure, and (c) special approval is obtained in advance.

APPENDIX E

STATE LAWS RESTRICTING SECOND TRIMESTER ABORTIONS TO HOSPITALS

1. Conn. Agencies Regs. § 19-13-D54 (1973);
2. Ga. Code Ann. § 26-1202(b) (1973);
3. Hawaii Rev. Stat. § 453-16(a)(2) (1970);
4. Idaho Code Ann. § 18-608.2 (1973);
5. Ill. Rev. Stat. ch. 111-1/2 ¶¶ 157-8.1 through 157-8.16 (1974);
6. Ind. Code § 35.1-58.5(b)(2) (1974);
7. Mass. Gen. Laws Ann. ch. 112, § 12N(2) (West 1974);
8. Mich. Admin. Code R. 325.3851 (1976);
9. Mont. Rev. Code Ann. § 94-5-618 (1974);
10. N.Y. Pub. Health Law § 4164 (McKinney 1974);
11. Okla. Stat. tit. 63, § 1-731.B (1978);
12. Tenn. Code Ann. § 39-301(e) (1973);
13. Utah Code Ann. § 76-7-302(2) (1974);
14. Va. Code § 18.2-73 (1975);
15. Wisc. Admin. Code § Med. 11.05 (1978);
16. N.J.A.C. 13:35-7.2 (1978).*

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* This rule provides that "within a period of gestation not exceeding 16 weeks" abortion using dilatation and evacuation may be performed in licensed health care facilities. Originally the rule would have limited all second trimester abortions to hospitals on an inpatient method regardless of the procedure used. However, as a result of a court challenge to the rule, the New Jersey Board of Medical Examiners amended the rule to permit the performance of abortions by dilatation and evacuation up to the sixteenth week of pregnancy. *Livingston v. N.J. Board of Medical Examiners,* 168 N.J. Super. 259 (App. Div. 1979), *certif. denied,* 82 N.J. 291 (1979).

In addition, such laws have been enjoined in six states: Ky. Rev. Stat. § 311.760(2) (1974); *Wolfe v. Stumbo,* C80-0285-L (A) (W.D. Ky. Dec. 3, 1980); La. Rev. Stat. Ann. § 1299.35.2 (1981); *Margaret S. v. Treen,* No. 78-2765 Sec. C (E.D. La. Nov. 27, 1981) (summary judgment); Mo. Ann. Stat. § 188.025 (Vernon 1978); *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft,* 664 F.2d 687 (8th Cir. 1981), *cert. granted,* 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-1623); Nev. Rev. Stat. 442.250.2 (1973), *Glick v. List,* CV-R-150 (BRT) (D. Nev. July 7, 1981) (*preliminary injunction*); Ill. Ann. Stat. ch. 38, § 8124 (1979); *Charles v. Carey,* 79 C4551 (N.D. Ill. Nov. 16, 1979) (preliminary injunction against criminal statute; regulation issued by Illinois Department of Public Health was not challenged in this action); N.D. Cent. Code, § 14-02.1-04.2 (1974); *Miks v. Olson,* Civ. No. A3-82-78 (D.N.D. June 11, 1982) (*preliminary injunction*) (plaintiffs have stipulated not to "willfully" perform abortions after the first trimester in a nonhospital setting).

APPENDIX F

CONSTITUTIONAL PROVISIONS

1. *United States Constitution, Article III, Sections 1, 2.*

Section 1.

The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services. a Compensation, which shall not be diminished during their Continuance in Office.

Section 2.

The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority; —to all Cases affecting Ambassadors, other public Ministers and Consuls; —to all Cases of admiralty and maritime Jurisdiction; —to Controversies to which the United States shall be a Party; —to Controversies between two or more States; —between a State and Citizens of another State; —between Citizens of different States; —between Citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the supreme Court shall have original Jurisdiction. In all the other Cases before mentioned, the supreme Court shall have appellate Jurisdiction, both as to Law and Fact, with such Exceptions, and under such Regulations as the Congress shall make.

The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury; and such Trial shall be held in the

State where the said Crimes shall have been committed; but when not committed within any State, the Trial shall be at such Place or Places as the Congress may by law have directed.

United States Constitution, Amendment I

Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

United States Constitution, Amendment XIV

Section 1.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

2. *Ohio Constitution, Article XVIII, Section 3*

Municipalities shall have authority to exercise all powers of local self-government and to adopt and enforce within their limits such local police, sanitary and other similar regulations, as are not in conflict with general laws.

LODGING

Nos. 81-746 and 81-1172

RECEIVED
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IN THE

Supreme Court of the United States

OCTOBER TERM 1982

CITY OF AKRON,

Petitioner,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners,

—v.—

CITY OF AKRON,

Respondents.

RESPONDENTS AND CROSS-PETITIONERS' LODGED MATERIALS MEDICAL AND STATISTICAL DOCUMENTS

JANET BENSHOOF
SUZANNE LYNN
NAN D. HUNTER
American Civil Liberties
Union Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

GORDON BEGGS
American Civil Liberties
Union of Cleveland
Foundation, Inc.
1223 West Sixth Street
Cleveland, Ohio 44113
(216) 781-6276

STEPHAN LANDSMAN
Cleveland-Marshall
College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328

Attorneys for Respondents and Cross-Petitioners

TABLE OF CONTENTS

Lodged Documents

UNITED STATES GOVERNMENT STATISTICS;
MEDICAL & SCIENTIFIC ARTICLES

Document #	*Documents*
1.	Cates, W., "Legal Abortion and Women's Health: Gains and Losses in the 1970's," study in record in *Planned Parenthood of Kansas City, Missouri v. Ashcroft,* U.S. S.Ct. No. 81-1255 (Pl. Exh. 3 to Cates Deposition, Df. Exh. 1, Transcript on Remand, offered p. 145, admitted pp. 145, 146); subsequently published as "Legal Abortion: the Public Health Record," *Science,* March 26, 1982: 1586-1590.
2.	U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, *Abortion Surveillance 1978,* November, 1980, study in record in *Planned Parenthood of Kansas City, Missouri v. Ashcroft,* U.S. S.Ct. No. 81-1255 (Pl. Exh. 4 to Cates Deposition, Df. Exh. 1, Transcript on Remand, offered p. 145, admitted pp. 145, 146); excerpts, pp. 1-12, 43, 48, 49.
3.	Cates, W. and Grimes, D.A., "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," *Obstetrics and Gynecology,* 58/4: 401-408, October, 1981, article in record in *Planned Parenthood of Kansas City, Missouri v. Ashcroft,* U.S. S.Ct. No. 81-1255 (Pl. Exh. 2 to Cates Deposition, Df. Exh. 1, Transcript on Remand, offered p. 145, admited pp. 145, 146).
4.	Lebolt, S.A. et al., "Mortality from Abortion and Childbirth: Are the Populations Comparable?" *Journal of the American Medical Association* 248/2: 188-191, July, 1982.

Document # *Documents*

5. Cates, W. et al., "Mortality from Abortion and Childbirth: Are the Statistics Biased?" *Journal of the American Medical Association* 248/2: 192-196, July, 1982.

6. Henshaw, S.K. et al., "Abortion 1977-1979: Need and Services in the United States, Each State and Metropolitan Area," The Alan Guttmacher Institute, New York, 1981; excerpts pp. 1, 3, 4, 5, 23-29, 33, 36, 39.

7. Henshaw, S.K. et al., "Abortion Services in the United States, 1979 and 1980," *Family Planning Perspectives* 14/1: 5-15, January/February, 1982.

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LEGAL ABORTION AND WOMEN'S HEALTH: GAINS AND LOSSES IN THE 1970s

Willard Cates, Jr., M.D., M.P.H.

Abortion Surveillance Branch
Family Planning Evaluation Division
Center for Health Promotion and Education
Centers for Disease Control

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
Centers for Disease Control
Atlanta, Georgia 30333

SUMMARY

The increasing availability and utilization of legal abortion in the United States had several important impacts on public health in the 1970s. It reduced deaths and complications among American women of childbearing age by providing less hazardous alternatives for women who choose to terminate an unwanted pregnancy; it allowed the development of safer surgical procedures for pregnancy termination; and it enhanced low-cost delivery of outpatient gynecologic services. However, legal abortion has been accompanied by developments of some concern--unethical practitioners, potential adverse outcomes in future desired pregnancies, and possibly higher risks of breast cancer in selected women.

KEY WORDS: Abortion, Abortion Morbidity, Abortion Mortality, Public Health, Women's Health

The increasing availability of legal abortion over the past decade has provided the annals of public health in the United States with one of its most rapidly changing chapters. A clandestine procedure before 1970, abortion has been thrust into the medical arena—where procedures can be performed more safely, techniques improved, and costs reduced. After 10 years, we now know more about induced abortion than any other surgical procedure.

Abortion is a controversial topic, and it is essential to use accurate and reliable data in arriving at policy decisions. The statistical data do not directly address society's ethical debate on the issue of abortion. However, the data objectively portray the public health impact for women of childbearing age resulting from the increased availability of legal abortion in the United States over the past decade.

The legalization of abortion has affected many areas of public health: deaths and complications among American women of reproductive age; the development of procedures for pregnancy termination; the delivery of abortion services to women; the costs of both the abortion procedure itself and its resultant complications; the formation of American families; and decision-making about human reproduction. However, the increasing availability of legal abortion has also produced areas of concern: unethical medical practices; potential obstetric sequelae; and possibly higher risks of breast cancer. In the remainder of this article, I will elaborate on these public health issues.

Deaths and Complications Among American Women of Reproductive Age

During the 1960s, abortion was largely illegal in the United States. Because of its criminal nature, no direct count of the annual number of illegal abortions was possible. Rather, estimates of the incidence of illegal

abortion were based on such approaches as local surveys using the randomized response technique (1), extrapolations from deaths and hospitalizations (2) or retrospective projections based on numbers of births and legal abortions (3,4). Because of the imprecision of these approaches, the best estimate of the annual range of induced abortion in the United States in the 1960s was between 200,000 and 1,200,000; the midpoint of this range is 700,000 illegal abortions per year (Figure 1).

These illegally induced abortions caused sizeable numbers of deaths and complications among American women of reproductive age. For example, in 1965, 235 deaths, or 20% of all deaths related to pregnancy and childbirth were attributed to abortion (5). Moreover, in the 1960s, complications from abortion accounted for nearly 20% of pregnancy-related admissions to municipal hospitals in New York and California (5); the average length of stay required to treat these complications was four days (5).

During the 1970s, the United States passed through three stages with regard to the availability of legal abortion: 1) until the middle of 1970, legal abortion was generally not available; 2) from mid-1970 through early 1973, it was available on a limited regional basis; and 3) since 1973, it has been generally available throughout the nation. During this time, the number of reported legal abortions increased from approximately 22,000 in 1969 to over 1.4 million in 1978 (6,7). Initially the increase in legal abortions was accompanied by a progressive decline in the estimated number of illegal abortions (Figure 1). Thus, most of the initial increase in legal abortions was due to a corresponding drop in illegal abortions (3,4,8).

This shift from illegal to legal abortions has had a documented impact on deaths to American women of reproductive age (9). In 1965, even before the

availability of legal abortion, deaths of women from all types of abortion began to decline more rapidly than other causes of death related to pregnancy and childbirth (Figure 2) Several explanations may exist for the decline in abortion-related deaths in the mid-1960s. First, the introduction of more effective contraception led to fewer unwanted pregnancies, which presumably reduced the need for illegal abortions. Between 1965 and 1970, oral contraceptives and intrauterine devices were used by an increasing percentage of married women (10) and this was associated with the decline in unwanted fertility during those years (11). Second, Tietze has speculated that illegal abortions may have shifted from the non-medical to the medical sector and become safer (3).

In 1970 the decline of abortion mortality rapidly accelerated and generally continued through 1976 (Figure 2). This accelerated decline further implies that legal abortions were primarily substitutes for illegal abortions. If abortions had been substituted for term births, then deaths to women from abortion should have increased relative to deaths from other pregnancy-related causes. Instead, the opposite occurred.

Categorization by the Centers for Disease Control (CDC) of all abortion-related deaths into one of three categories--legally induced, illegally induced, or spontaneous--permits an even clearer view of these trends (Figure 3). In 1972, there were 90 abortion-related deaths, while in 1979 there were 29. Through 1976, the highest proportion of this decline occurred in the illegally induced category, where the number of deaths to women decreased from 39 in 1972 to 2 in 1976. The reduction in illegal abortion mortality had a distinct temporal association with the increasing availability of legal abortion.

After 1976, mortality from legally induced abortion declined markedly (Figure 3). During the initial years of CDC's surveillance of abortion-related mortality, the number of deaths after legally induced abortion increased slightly, consistent with the increasing number of women obtaining legal abortions. In 1976, however, the number of deaths from legally induced abortion decreased precipitously and has remained at a lower level through 1979, despite a continuing increase in the number of procedures performed. Thus, the death-to-case rate for legal abortion has declined (Figure 4).

Morbidity trends for abortion in recent years parallel mortality trends. Studies performed at national, state, and local levels show that hospitalization of women with complications resulting from abortion has decreased. Estimates based on the Hospital Discharge Survey from 1970-1977 show a general decline in hospital discharges for women with complications from other-than-legal abortions; the greatest part of this decline occurred in 1973, immediately after the Supreme Court decisions (12). In addition, individual hospitals on both the east and west coasts have shown similar declines (13-19).

These reductions in mortality and morbidity have occurred primarily because legal abortion is safer than any other alternatives available to pregnant women. Once pregnant, a woman is at increased risk of death as the pregnancy progresses, no matter what her choice of outcomes. The acceptability of risks to the woman associated with pregnancy and childbirth may vary depending on whether her pregnancy is wanted.

Besides legal abortion, the two options for a pregnant woman are illegal abortion or carrying the pregnancy to term. Compared to illegally induced

procedures, legally induced abortion is markedly safer. Compared with continuing the pregnancy to term, terminating a pregnancy by legal abortion is associated with lower morbidity (20,21) and mortality (22). For example, between 10%-15% of term births are delivered by cesarean section (23), whereas only 0.07% of first trimester abortion procedures result in intra-abdominal operations (24). Likewise, second trimester abortion methods lead to major surgery in only 0.1% to 0.2% of cases (25). Therefore, the risk of having to undergo major surgery for a complication of a legal abortion is approximately one one-hundredth that of carrying a pregnancy to term. The relative safety of legal abortion is apparent.

Moreover, the rates of severe psychiatric sequelae and death are lower for women who obtain legal abortion compared to those who continue their pregnancies. The risk of severe emotional problems is higher with a live birth following a normal pregnancy than with a legal abortion (26,27). Regarding mortality measures, the risk of dying from induced abortion during the first 15 weeks of pregnancy is one-seventh the risk of dying from pregnancy and childbirth (Figure 5), even after standardizing the population groups for differences in age and race (22).

The increased risk to the woman of continuing rather than terminating her pregnancy may be further exaggerated when the pregnancy is unwanted. Women with negative attitudes toward their pregnancies have higher postpartum infection and hemorrhage rates than women with more favorable attitudes (21). Possible mechanisms for these poorer obstetric outcomes associated with unwanted pregnancies include a direct stress-mediated influence on catecholamines (28), less concern by the woman for proper pre-natal care or differences in clinical management of labor and delivery (21).

Development of Abortion Techniques and Expertise

The increased availability of legal abortion in the United States since 1970 has influenced both the safety of abortion methods and the skill of the clinicians performing abortions. The six-fold increase in the number of abortion procedures over a relatively short interval has led to rapid development of technology (29). The most influential change has been the widespread adoption of the vacuum aspiration technique (suction curettage) to evacuate the uterus (30) which replaced the traditional scraping technique (sharp curettage) as the primary means of terminating pregnancies. In 1970, the proportions of procedures performed by suction and sharp curettage were similar--54% were performed by suction and 46% by sharp (24). Over the next nine years, the percentage of suction curettage procedures gradually increased. By 1978 suction curettage accounted for 90% of all curettage procedures. Of those curettage methods used at 12 weeks or earlier, 96% were performed by suction (6).

Another improvement has been the recognition that curettage techniques can terminate pregnancies at 13 weeks' gestation or later more safely than the other alternative methods (31); thus, delaying an abortion through the 13 to 16 week interval, required for the instillation of abortifacients into the uterus, is not appropriate. Before legal abortion was available, performing curettage on a pregnant uterus after 12 weeks was thought to be too dangerous. Once abortion became legal, however, comparative studies could be undertaken to determine the safest methods of terminating pregnancy after 12 weeks. Through these studies, we have learned that curettage techniques, especially through 16 weeks' gestation, are safer than instillation procedures

(31,32). As a result, curettage has become the preferred procedure to terminate these later pregnancies over recent years (32).

The legalization of abortion has allowed clinicians the opportunity both to learn different surgical techniques and to manage the immediate complications associated with these techniques. Before the availability of legal abortion, very few pregnancy termination procedures were taught in routine obstetric and gynecologic training programs (33). The only experience with uterine evacuation for residents in training usually came either when performing sharp curettage on a non-pregnant uterus for diagnostic purposes or when removing residual uterine tissue after a routine miscarriage. These procedures are different from those involved in evacuating a pregnant uterus.

The increase in physician training and experience may be one factor (33,34) contributing to the decrease in deaths related to legally induced abortion after 1975 (Figure 4). The death-to-case rate for legal abortion has decreased from 6.2 per 100,000 procedures in 1970 to 0.6 in 1978 (6). Improvements in anesthesia technique, use of more appropriate methods of dilatation, reductions in the percentage of major operative procedures for abortion (i.e., hysterotomy or hysterectomy), greater willingness to re-evacuate a uterus in cases of suspected retained tissue, and physician familiarity with other abortion complications all may have played a role.

Delivery of Abortion Services

The increasing availability of and requests for abortion services have also led to two changes in when and where they are delivered: first, women obtaining legally induced abortions are doing so at progressively earlier gestational ages (6); second, most abortions are now being performed in non-hospital facilities, the so-called "freestanding clinics" (7). These two

factors concurrently influence the safety, convenience, and cost of abortion procedures.

In 1970, nearly one out of every four abortions was performed at gestations of 13 weeks or later. By 1978, less than one in ten abortions was performed later than 13 weeks (6). Moreover, even within the first 12 weeks, there has been a shift toward obtaining procedures earlier in gestation: in 1978, over half of all women having abortions terminated their pregnancies before 8 weeks' gestation (6). Because gestational age is an important factor and affects the risk of complications after legally induced abortion (20), the trend toward obtaining abortions earlier in gestation has contributed to reducing the number of deaths and complications from this procedure.

Before the legalization of abortion, the term "in-hospital" was generally used to describe legal abortion procedures (35). In 1970, women were frequently hospitalized for at least two days in order to have a legally induced abortion: the first night was for preoperative evaluation, while the second night was for postoperative recovery (36). Even in 1973, over 60% of all abortions were performed in hospitals. However, during the past 6 years, the situation reversed itself (7). By 1979, over 70% of abortion procedures were performed in freestanding clinics, without any hospitalization; about half of those performed in hospitals were on an outpatient basis (7).

Costs of Medical Care

The increasing availability of legal abortion has affected its cost. Before 1969, if it could be obtained, therapeutic abortion frequently cost over $500 (37). For this reason, women of higher socioeconomic levels were more likely to obtain therapeutic abortions (35). Today, uterine evacuation procedures performed in clinics are usually no more than $150 (38).

The developments in abortion technology and the increasing use of freestanding clinics have further reduced costs. For example, curettage procedures to terminate pregnancies of more than 12 weeks' gestation cost approximately one-half that for instillation procedures. Also, use of non-hospital facilities obviates the hospital charges that have played a major role in increasing the cost of medical care in the United States. The average room charge for one day in a hospital is more than the cost of a suction curettage procedure in a freestanding clinic (38).

The increasing availability of legal abortion procedures has also reduced the cost to society of treating abortion complications. The substitution of legal for illegal abortion led to an estimated saving of $30 per aborting woman in public expenditures for treating infected and/or incomplete abortions (39). The improved safety of legal abortion techniques has also decreased abortion complications and resulting costs. Assuming a national decrease in morbidity similar to that in mortality, the 75% reduction in complications would save approximately $20 million annually (40).

Formation of American Families

Marriage and childbearing patterns have been measurably influenced by legal abortion; so has the formation of American families. In the United States before 1969, trends in marriage rates among states with different levels of legal abortion services were similar (41). Beginning in 1970, states with high legal abortion-live birth ratios began exhibiting significant declines in marriage rates, especially among teenage women, not experienced by states with lower legal abortion ratios (41). Liberalized abortion policies apparently provided many teenagers with a new alternative to high-risk marriages precipitated by a premarital pregnancy. These marriages are less stable than those of their contemporaries who postpone childbearing (42).

Legalization of abortion has been temporally associated with a decline in out-of-wedlock birth rates in New York City (43), California (44), Oregon (45), and the United States as a whole (46). Since most teenage out-of-wedlock births were unwanted (42), and since more than 85% of abortions performed on teenagers have been obtained by unmarried women, some increase in the number of abortions among teenagers probably affected unintended fertility. States with the highest teenage and overall childbearing rates had the lowest abortion-to-live-birth ratios (47,48).

For American families at known risk of genetic anomalies, the availability of amniocentesis and selective abortion has allowed couples either to undertake pregnancies they might never have considered or else to continue pregnancies that they would have terminated. If the option of legal abortion were not possible, 10% of women in Buffalo undergoing amniocentesis would not otherwise have initiated or continued their pregnancies (49). A national survey of genetic centers (50) identified 67 women who terminated their pregnancies specifically because prenatal diagnosis was not available; most of these women were at low risk (under 2%) of having a defective child, thus they would have continued their pregnancies if provided the reassurance of prenatal diagnosis.

Decision Making About Reproduction

As American consumers have increasingly demanded more information about health services, many family planning providers have developed elaborate counseling protocols to aid women with unwanted pregnancies in making responsible decisions (38,51). A random survey of abortion providers in 1976 showed 98% of clinics and 60% of hospitals reported offering pregnancy counseling services (38); 100% of clinics and 60% of hospitals provided

contraceptive counseling. Based on in-depth interviews, most women considering pregnancy termination claim not to take their decision lightly (51-53). Many have already made responsible decisions about their reproductive behavior before becoming pregnant (53). Others, especially teenagers without benefit of rudimentary sexual knowledge, find the situation of an unwanted pregnancy the first important decision point in their lives (51).

The increasing utilization of legal abortion is associated with an increasing proportion of women using contraception even after adjusting for sexual activity. Four different methodologic approaches have supported this inference. First, longitudinal studies documented an increase in the percentage of women using contraception immediately after an abortion compared with before the pregnancy; these women continued to use effective contraception methods at least 6 months afterwards (54,55).

Second, national studies of reproductive behavior conducted between 1965 and 1975 demonstrated an increasing percentage of married women using contraception even as legal abortion was becoming more widely available (56). Moreover, the largest incremental annual increases, 3% per year, occurred between 1973 and 1975.

Third, the national patterns of increasing sexual activity (57) and declining birth rates (58) indicate that women are becoming increasingly able to control their fertility through either contraceptive practice or abortion. The proportion of never-married teenagers having unprotected intercourse decreased by one-half between 1971 and 1979 (57). Moreover, in 1976, young unmarried women who became pregnant unintentionally and had an abortion were probably more likely to be using contraception before their abortion than women who did not have an abortion (59).

Fourth, between 1960 and 1974, the national conception rates actually decreased, if allowances are made for the number of illegal abortions performed in earlier years (60). In New York City, the conception rate also declined during the initial three years legal abortion was available (61).

Unethical Medical Practices

Because of the relatively low fees for abortion procedures, abortion providers would have to perform a large number of legal abortions to enhance profit. These competitive pressures lead some facilities and clinicians to use practices considered unethical by many (62). While the magnitude of these unethical practices is not precisely known, the relatively low overall rates of morbidity and mortality after legal abortion would indicate they are not widespread.

Investigations in four cities (Detroit, Los Angeles, Chicago, and New York) have documented occasional questionable medical practices such as 1) misleading "pregnancy counseling" agencies which use high-pressure tactics and false information to refer women to a subsidiary abortion facility; 2) "abortion" procedures deliberately performed on non-pregnant women without their informed consent; 3) operations performed by unlicensed personnel--either non-physicians masquerading as physicians or physicians who have previously lost their license to practice; and 4) facilities which are deliberately operated without state licenses and whose personnel knowingly falsify required medical records.

Besides the unethical practices, some physicians have deliberately performed dangerous abortion procedures. One practitioner allegedly performed intentional incomplete abortions which would require a second procedure; thus, he could bill for two separate operations (63). This practice not only

involved fraudulent billing, but also put women at higher risk of morbidity and mortality; one woman eventually died from infection resulting from retained products of conception. Another physician performed vaginal hysterotomy procedures in his private office (64). He was not equipped to handle the operative emergencies which occurred. Two women died from these procedures. Both physicians were found guilty of criminal offenses.

In other situations, use of outdated or unproven methods by some clinicians have led to sporadic clusters of deaths and complications (65,66). For example, intrauterine placement of a "super coil" to terminate second trimester pregnancies led to unacceptably high complication rates (65). While this specific procedure has been abandoned, deaths still occur from use of indwelling foreign bodies by licensed physicians (67).

Finally, in at least two instances, abortion providers have admitted charging one fee for women funding their abortions through private sources and a second fee, two to three times higher, for women using public funding sources (68). Although the offenders claim these billing practices are necessary to underwrite the paperwork required for, and the delay inherent in, government third-party payments, the magnitude of these differences is hardly justifiable.

These unethical practices have been attacked by both abortion providers and those opposed to abortion. Most responsible abortion providers are concerned that the questionable medical practices will both endanger women's health and taint the safety record of legal abortion; as such, they have cooperated with investigative organizations to identify the problem practitioners (69) and have developed model standards to improve their already relatively safe procedure (62). Groups opposed to abortion have highlighted

the isolated events as representative of the poor medical care delivered by abortion providers and have used them as a basis to regulate all abortion services (70).

Future Childbearing

Recent headlines have reported that women with prior induced abortions, especially previous multiple abortions, have an increased risk of adverse events in future desired pregnancies. These preliminary reports have led some to predict an epidemic of miscarriages, prematurity, and low-birth-weight infants in the future (71).

Unfortunately, the best available data addressing this issue do not permit a precise estimate of such risks, if any (72-75). The recent scientific literature from the United States is inconsistent about whether one abortion, or even multiple abortions, were associated with increased rates of adverse reproductive outcomes in subsequent desired pregnancies. Of the 8 studies currently published, two (76,77) have demonstrated a significant association of a single induced abortion on subsequent childbearing; the others (78-83) have found either no association or such a small level of risk that chance could have accounted for the difference. Two published studies (82,83) have implicated multiple induced abortions as factors leading to 3-fold higher risks of miscarriage, but one preliminary report from Hawaii (84) could not confirm this finding.

Several studies outside the United States (85-87) have demonstrated significant associations implicating a particular abortion procedure, especially the practice of sharp curettage. Since variations in abortion methods produce different short-term complications, they might also be expected to have different effects on long-term obstetric sequelae. For

example, traditional sharp curettage frequently involves wider dilatation than current suction procedures (27). If the manner and/or width of dilatation, rather than the number or method of evacuation procedures, influence future pregnancies, use of laminaria for preoperative cervical dilatation might reduce risks (83).

Differences among the characteristics of women studied also produce conflicting results (75). For example, parity has an important effect on pregnancy outcome (88), with first births being at higher risk of preterm delivery than subsequent births. Thus, investigations which compare first births of women with a previous abortion to second births of women with a previous term birth will tend to find more complications among the abortion group, spuriously due to differences in parity (75).

Breast Cancer

Whether induced abortion is associated with subsequent development of breast cancer is another area of increasing concern (89). Previous international investigations have shown that a woman is at lower risk of developing breast cancer if she gives birth at a young age (90). However, only full-term pregnancies afford this protection. If the first pregnancy terminates within 4 months' gestation, a woman appears to have an increased risk of breast cancer (91-95). Unfortunately, these earlier studies did not differentiate between induced and spontaneous abortion.

A recent investigation in Los Angeles (89) found breast cancer in young women was over 2-fold higher if they had experienced either an induced or a spontaneous abortion. Two specific conditions were necessary: 1) the abortion has to occur before 3 months' gestation; and 2) the woman had to be nulliparous at the time of the abortion. A biologic explanation for a

possible positive association between early abortion and breast cancer, and a negative association between early age at first childbearing and breast cancer, might involve variations in breast tissue during different intervals of pregnancy (96). Early in pregnancy, rapid proliferation of breast tissue might render more cells susceptible to neoplastic stimuli (tumor initiation), or might hasten the growth of malignant cells (tumor promotion). The protective effect of continuing a pregnancy to term could involve either breast cell differentiation later in pregnancy, and/or a permanently altered estrogen profile during the later stages of gestation (97).

While data from this investigation are consistent with earlier findings, the case-control designs raise questions of ascertainment bias. Specifically, could women with breast cancer be more likely to remember and/or admit previous abortions than a comparison group? Also, women in the Los Angeles study had their cancers diagnosed prior to age 32 (89). The incidence of breast cancer in this age group is very low, about 20 per 100,000 women (96). Whether any association between abortion and breast cancer occurs later in life has not been documented. If that association is not found, then the public health impact of abortion on breast cancer incidence, if any, would be very small. Further investigations may cast light on these important questions.

Conclusion

To summarize, the increasing availability and utilization of legal abortion in the United States has had an important public health impact in the 1970s. Like any social phenomenon, the issue of legal abortion has its advantages and disadvantages. Accurate and reliable information will help policy makers, practitioners and American women make more rational decisions

on abortion. The data clearly indicate the legalization of abortion has been accompanied by a decline in deaths and complications among American women of childbearing age by providing a safer alternative for women faced with unwanted pregnancies. It also led to the rapid development of technological advances and clinical expertise in pregnancy termination procedures. It stimulated development of more convenient, low-cost outpatient health services. However, legal abortion has also brough with it areas of concern--unethical practitioners, potential adverse outcomes of future desired pregnancies and possibly higher risks of breast cancer in selected women.

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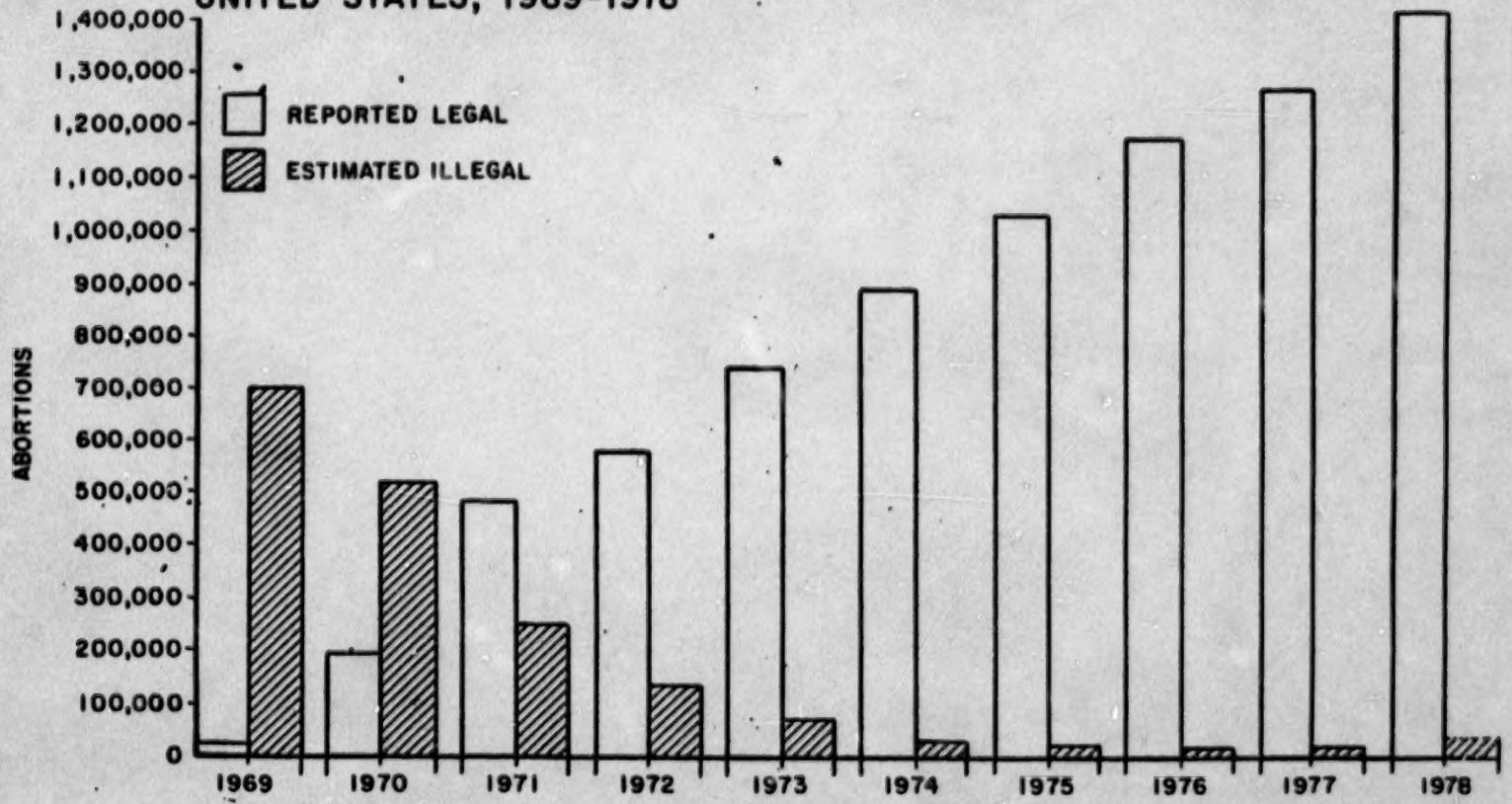
Fig. 1 RELATIONSHIP BETWEEN LEGAL AND ILLEGAL ABORTION, UNITED STATES, 1969-1978



Sources: Illegal abortion - extrapolation from references 1-4
Legal abortion - references 6 and 7

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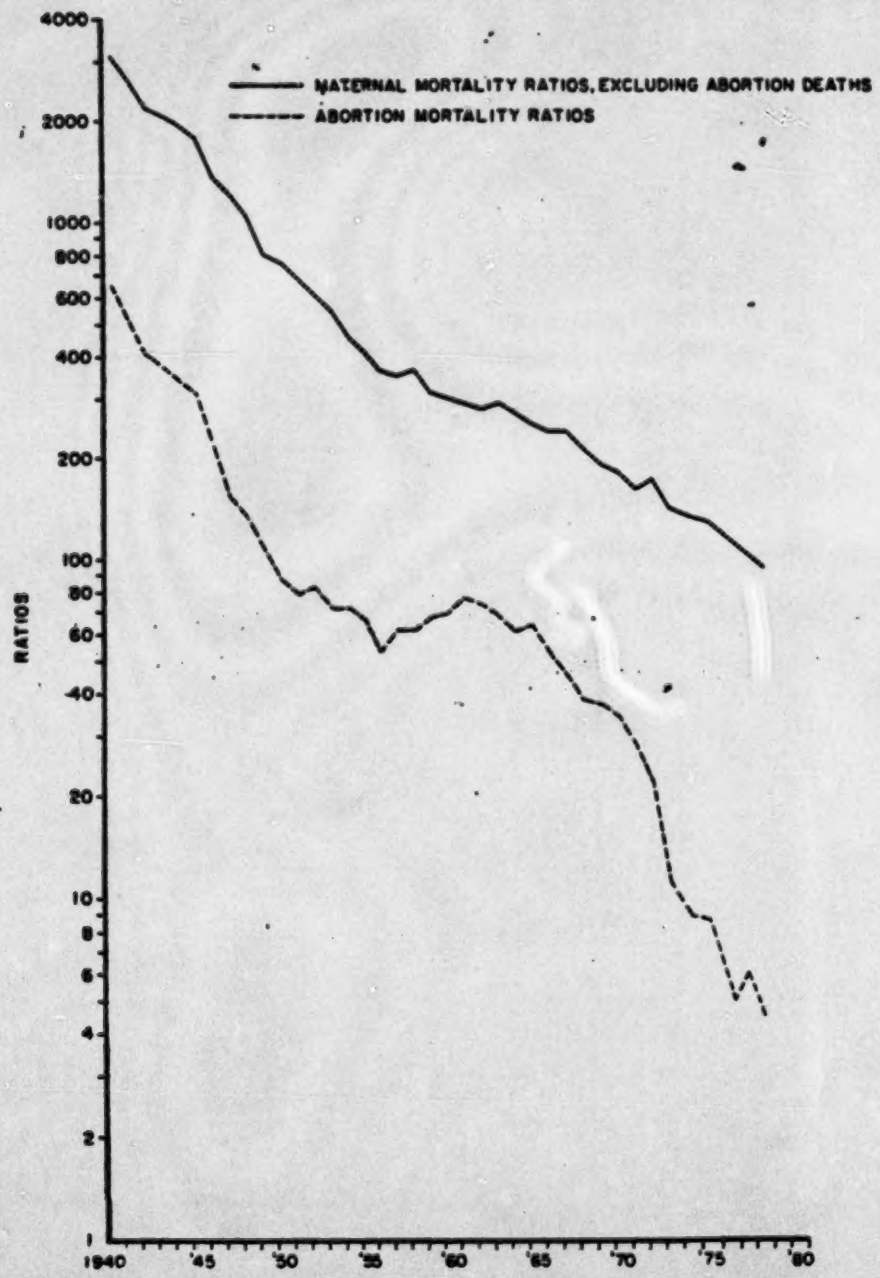
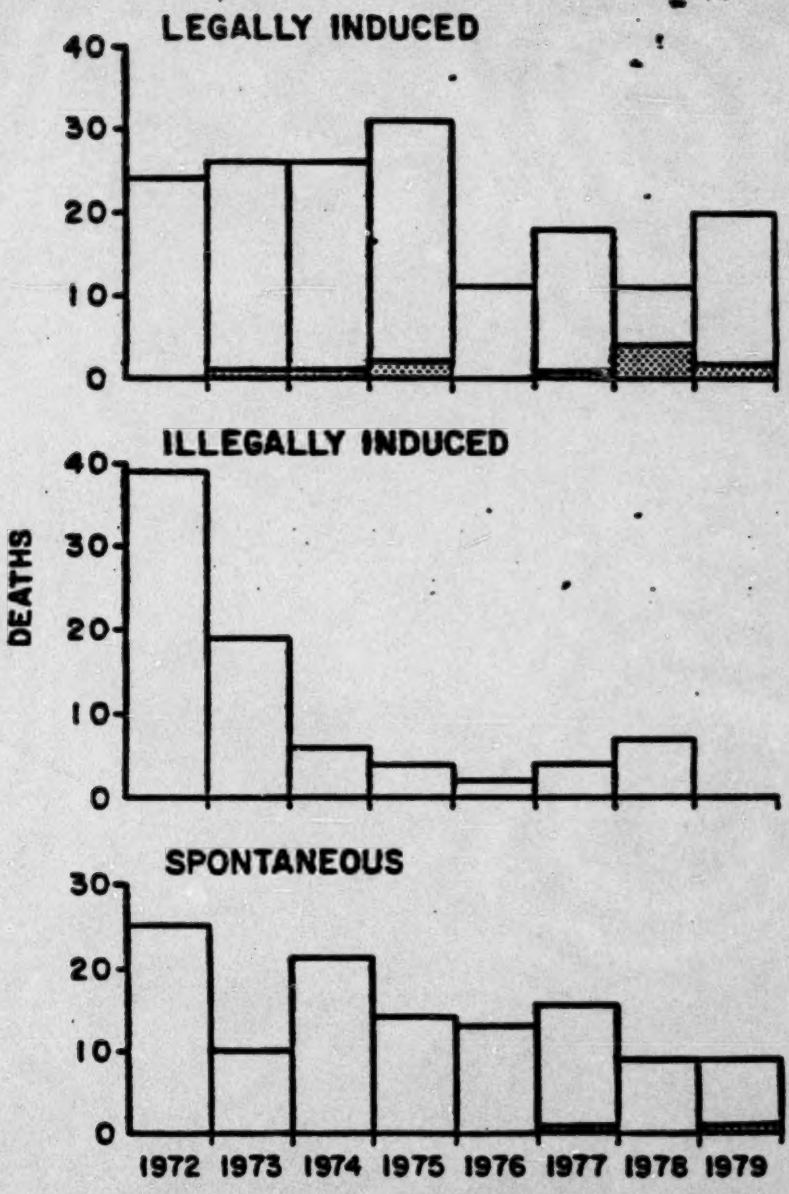
Fig. 2 MATERNAL MORTALITY RATIOS (EXCLUDING ABORTION DEATHS)[1,2] AND ABORTION MORTALITY RATIOS[2], UNITED STATES, 1940-1978[3]



[1]Maternal mortality ratio (excluding abortion deaths) equals total maternal deaths minus abortion deaths per 1,000,000 live births
[2]Abortion mortality ratio equals total abortion deaths per 1,000,000 live births

Source: National Center for Health Statistics. U.S. Vital Statistics, 1940-1978.

Fig. 3 ABORTION-RELATED DEATHS BY CATEGORY* AND YEAR,** UNITED STATES, 1972-1979



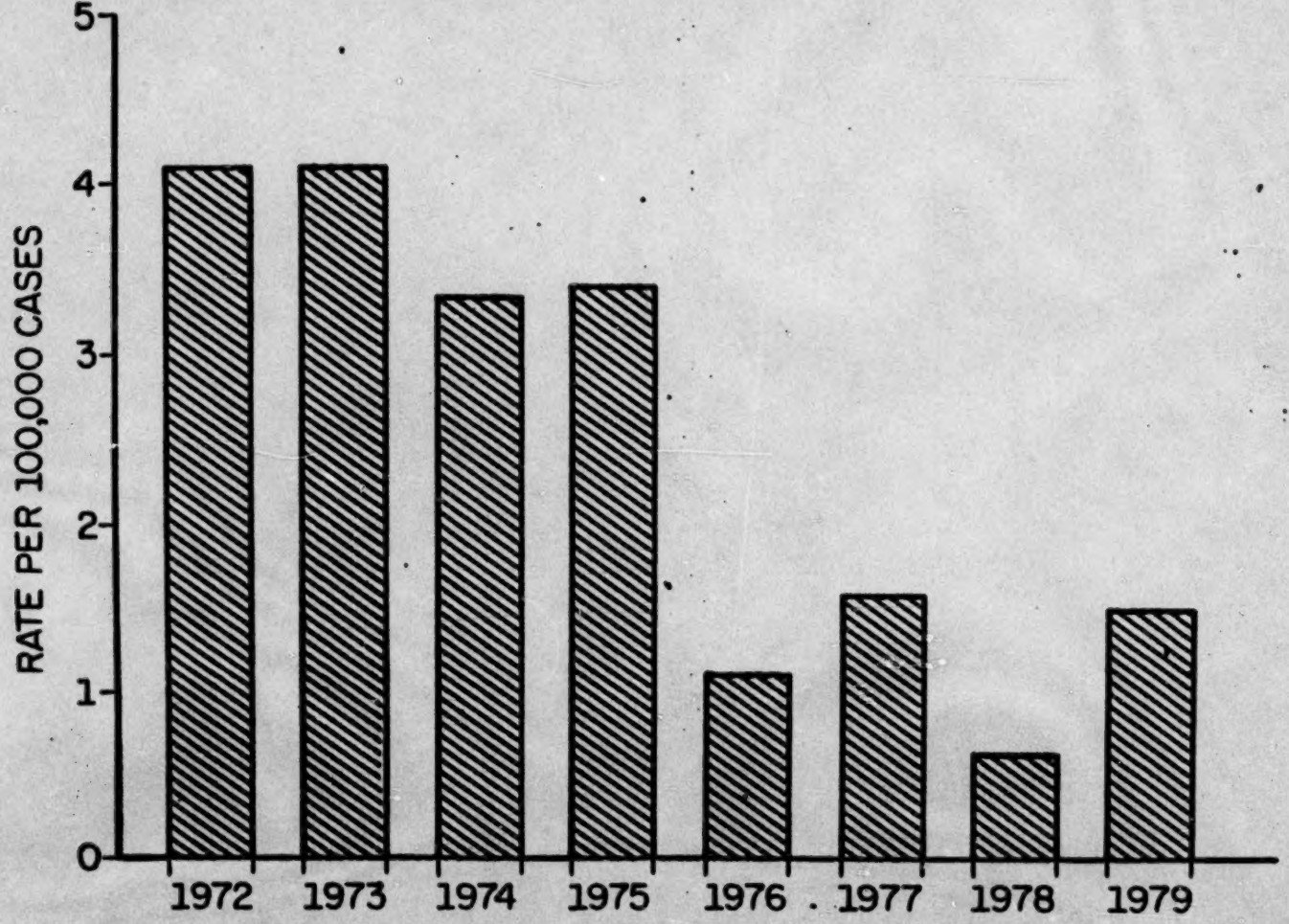
*EXCLUDES UNKNOWN CATEGORY
**1979 DATA ARE PROVISIONAL

ECTOPIC PREGNANCY

Source: Centers for Disease Control. MMWR Annual Summary, 1980.

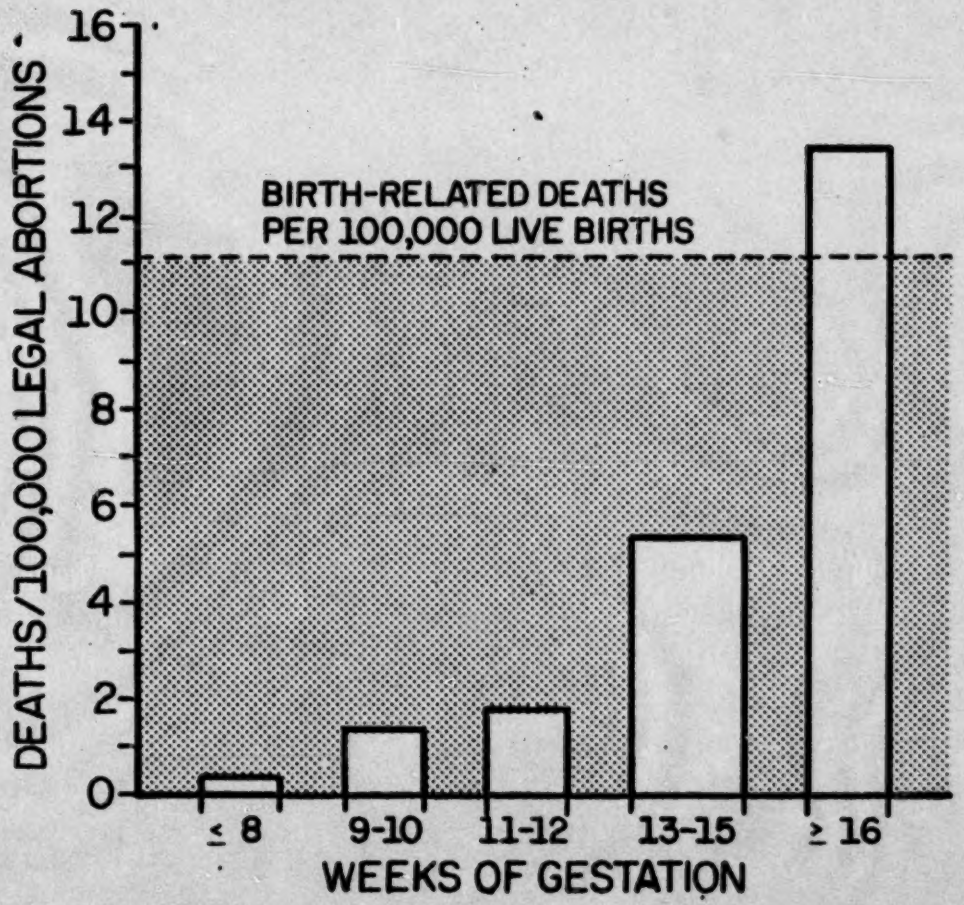
Fig. 4

DEATH-TO-CASE RATES FOR LEGAL ABORTION, UNITED STATES, 1972-1979



Source: Centers for Disease Control

Fig. 5 DEATH-TO-CASE RATES FOR LEGAL ABORTION BY WEEKS OF GESTATION, COMPARED WITH BIRTH-RELATED MORTALITY RATE, U.S., 1972-1978



Sources: Centers for Disease Control and National Center for Health Statistics

Document #2

ANNUAL SUMMARY 1978
Issued November 1980

CENTERS FOR DISEASE CONTROL

ABORTION

SURVEILLANCE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service

I. SUMMARY

In 1978 the 50 states and the District of Columbia reported 1,157,776 legally induced abortions to the Center for Disease Control, a 7% increase over 1977. The national abortion rate rose from 22 per 1,000 females aged 15-44 in 1977 to 23 in 1978. The national abortion ratio increased by 7%, from 325 to 347 per 1,000 live births, or more than 1 abortion for every 3 live births.

As in previous years, women who obtained abortions in 1978 were most often young, white, unmarried, and of low parity. Sixty-five percent were less than 25 years of age; 67% were white, and 33% were of black and other races. Seventy-four percent of all women obtaining abortions were unmarried at the time of the procedure, and 57% had had no live births. Curettage continued to be the most widely used procedure for reported legal abortions, accounting for 95% of abortions performed in 1978. Compared with 1977, the percentage of saline instillation procedures used after 15 weeks' gestation decreased, dilatation and evacuation procedures increased, and instillation of prostaglandin and other agents remained the same.

Women continued to seek abortions at earlier gestational ages; over half (52%) of all abortions were performed at less than 9 menstrual weeks' gestation, and 91% of abortions were induced within the first 12 weeks. Younger women obtained abortions at later gestations than older women. Nearly half (46%) of the abortions performed after 15 weeks of gestation were to women 19 years of age or younger. A woman's race had relatively little impact on the gestational age when she obtained an abortion.

In 1978, 27 women died from abortion, 8 fewer than the 35 who died in 1977. Compared with 1977 there was a decline in the annual number of legally induced abortion deaths; 11 women died after legally induced abortion in 1978, compared with 17 in 1977, 11 in 1976, and 31 in 1975. Four of the 11 deaths in 1978 were due to ectopic pregnancy after attempted legally induced abortion. In 1978 there were 7 deaths after illegally induced abortion and 9 deaths after spontaneous abortion. The death-to-case rate for legally induced abortions decreased from 1.4 in 1977 to 0.6 per 100,000 abortions in 1978.

The role of oxytocin in augmenting the uterine activity of second-trimester instillation abortions is controversial. To evaluate the efficacy and safety of oxytocin augmentation, we analyzed data on 10,013 women who underwent hypertonic saline instillation procedures and 1,241 women who underwent prostaglandin F2a (PGF2a) instillation procedures in the United States between 1971 and 1975. Data were obtained through the Joint Program for the Study of Abortion under the auspices of the Center for Disease Control, a multi-center, prospective, cohort study. We found that concurrent administration of oxytocin was associated with a significantly shorter instillation-to-abortion time for hypertonic saline but with a significantly longer time for PGF2a. For hypertonic saline, use of concurrent oxytocin did not affect either the success rate or the major complication rate; however, it did affect the specific type of complication that occurred. For PGF2a, use of concurrent oxytocin was associated with a lower success rate and a higher major complication rate than when PGF2a was used alone; however, the relatively small number of observations and limitations in our study design may have affected our results.

In August 1977 federal funds for financing abortions of Medicaid-eligible women were restricted. In order to study the health impact of public fund restriction, we reviewed the medical records of women with abortion complications in 3 cities for 1 year before and 1 year during the restriction. A similar analysis was done for 3 cities where public funding for legal abortions had not been restricted. Assuming that the number of complications reflects the number of abortions, we found that the restriction of public funding for legal abortions had not increased the number of illegal abortions, but that it had reduced the number of legal abortions obtained by poor women.

An estimated 30 to 55 million abortions are performed worldwide each year, making abortion one of the most prevalent means of fertility control. The majority of the world's population (60%) live in countries where abortion is permitted either on request or for social reasons. The United States was sixth of the 18 countries reporting abortion rates and eighth of the 16 countries reporting abortion ratios. In 1978 the United States reported one of the lowest percentages of abortions to women over 40 years of age (< 3%) and to women with 4 or more children (4%) and one of the highest percentages to never-married or previously married women (74%) and to women with no living children (61%).

II. NUMBER AND CHARACTERISTICS OF WOMEN RECEIVING ABORTIONS

A. Surveillance Methods

CDC receives abortion statistics by state of occurrence from 3 types of sources: 1) central health agencies, 2) hospitals and/or facilities, and 3) the Cooperative Health Statistics System (CHSS) of the National Center for Health Statistics. Table 1 summarizes the development of CDC's abortion reporting sources since the initiation of epidemiologic surveillance of abortion in 1969. The areas (including the District of Columbia) which report abortion data to CDC or CHSS have increased from 8 states in 1969 to 48 reporting areas in 1978. Central health agencies receive information either from direct reporting systems or from surveys of hospitals or abortion facilities within the state. For 1978, 40 agencies provided data directly to CDC, and 8 agencies provided data to the CHSS, which is projected to become the national data-gathering mechanism. To obtain information for this report from the 4 states which did not collect statewide abortion data, CDC directed inquiries to the hospitals and facilities in those states. Figure 1 reflects the sources of reported abortion data by state for 1978.

B. Tabulation Methods

In the past CDC has published univariate tabulations, where provided by the state, on the following variables: number of abortions, residence status, age, race, marital status, number of live births, method of abortion, weeks of gestation, and number of previously induced abortions. We also have published bivariate tabulations of abortions by weeks of gestation and type of procedure. Beginning in 1978, we are publishing the following additional bivariate tabulations, where provided by the state either directly or through the CHSS system: weeks of gestation by age, weeks of gestation by race, age by race, and marital status by race.

Percentages shown in the Summary Table may differ slightly from those in the corresponding tables, since in the former the percentages were based on known distributions. Similarly, percentages in the bivariate tables were calculated after the unknowns were excluded. Because California collected data by the variables listed above for 1976 but not for 1977 or 1978, the percentage of all abortions for which CDC has variable-specific data is lower in 1977 and 1978 than in 1976.

Live-birth data used in calculating abortion ratios were obtained from the Vital Statistics Division, National Center for Health Statistics.

C. Number of Abortions by State of Occurrence

In 1978 the 50 states and the District of Columbia reported 1,157,776 legal abortions, an increase of 7% over the 1,079,430 legal abortions reported in 1977. New York and California reported the largest number of abortions (Table 2), as they have consistently done since 1970. In 1978 these 2 states provided 28% of the national total, approximately the same percentage as in 1977 and 1976. Alaska, Idaho, New Hampshire, North Dakota, South Dakota, and Wyoming each reported fewer than 2,500 abortions in 1978. The majority of states reported an increased number of abortions performed in 1978, with only 5 states reporting a decline (Table 3). The largest percentage increases were reported from Idaho (98.8%) and Arkansas (83.9%), while the largest decreases were reported from Alaska (37.7%) and Ohio (13.1%) (Table 3).

The national abortion ratio rose in 1978 to 347 abortions per 1,000 live births, a 7% increase over 1977 (Table 1). The abortion ratios ranged from a low of 74 in Mississippi to a high of over 1,000 in the District of Columbia (Table 2). Only 7 of the 50 reporting states recorded a decrease in the abortion ratio from 1977.

The national abortion rate rose in 1978 to 23 abortions per 1,000 females aged 15 to 44, a 5% increase over 1977 (Table 1). The abortion rate ranged from a low of 6 in Alaska and Mississippi to a high of 38 in the State of New York and 171 in the District of Columbia (Table 2). The majority of the states (78%) reported an increase in the abortion rate in 1978. Only 6 states and the District of Columbia reported a decrease in the abortion rate from 1977.

D. Residence Status

In 1978, 11% of abortions were performed for out-of-state residents (Table 4), a percentage similar to that reported for 1975, 1976, and 1977 (Summary Table). In 1978 the residence status was known for 64% of women who had reported abortions. The largest proportion of abortions for out-of-state women in 1978 was again reported by the District of Columbia (54%) (Table 4). South Dakota and Kansas were next highest, both reporting nearly 40%. Declines in the percentages for out-of-state women occurred in 18 of the 39 states reporting residence status in 1978. The greatest proportion of women obtaining abortions outside their state of

residence resided in the East South Central Division (24%) and the smallest in the Pacific Division (1%) (Table 5). This is consistent with information reported in 1975, 1976, and 1977. Approximately half of resident abortions were obtained out of state in South Dakota, West Virginia, and Mississippi, while less than 1% of resident abortions were obtained out of state by women in New York, Minnesota, Colorado, Oregon, and Hawaii.

E. Age

Thirty-seven states and the District of Columbia reported abortions by age in 1978, comprising 66% of all reported abortions (Table 6). In 1978, 30% of women obtaining abortions were aged 19 or younger, 35% were 20 to 24 years old, and 35% were age 25 or older (Summary Table). This represents a continuation of the trend present since 1975 of a gradual shift from the group less than 20 years old to the 20- to 24-year age group (Summary Table and Figure 2).

In 1978 Arkansas, Kansas, Minnesota, Nebraska, New Hampshire, and South Dakota had the largest percentage of women younger than age 20 (approximately 40%); Hawaii, New Jersey, New York, and the District of Columbia had the largest percentage of women aged 25 and older (slightly more than 40%). This is a similar pattern to that reported in 1977.

A total of 32 states reported abortions by single year of age for women 15 to 19 years old (Table 7). Approximately 58% of the 189,125 abortions to women less than age 20 were obtained by women 18 years or older and 10% by women 15 or younger. This represents a slight shift to the older teenage group since 1977.

Women younger than 15 years old had the highest ratio of legal abortions to live births (1,149) followed by women 40 years old and older (788) (Table 6). The lowest abortion ratio was reported for the 25- to 29-year-old age group, 218 abortions per 1,000 live births. All age groups except the <15-year age group had a reported increase in the abortion ratio from 1977 (Figure 3).

F. Race

Although the majority (67%) of abortions in 1978 were performed on white women, the percentage of women of black and other races having abortions showed a slight decline for the first time since 1972 (Summary Table). Thirty-two states and the District of Columbia reported race in 1978, comprising 53% of all reported abortions (Table 8). Both Hawaii and the District of Columbia reported a majority of abortions for women of black and other races, and New York City and Louisiana reported more than 40% of abortions to women of black and other races.

Women of black and other races continued to have a higher abortion ratio than whites (Figure 4). Compared with 1977, the abortion ratio for blacks and other races increased from 490 per 1,000 live births to 497, and for whites it increased from 268 to 297 (Table 8).

G. Marital Status

In 1978 the majority of women (74%) obtaining abortions were unmarried at the time of abortion; this is a slightly lower proportion than the 76% reported in 1977, and it reverses the trend of increasing proportions of unmarried women observed since 1972 (Summary Table). Thirty-one states and the District of Columbia reported marital status in 1978, comprising 53% of all reported abortions (Table 9).

In 1978 unmarried women continued to have higher abortion ratios than their married counterparts (Table 9, Figure 5). The aggregate abortion ratio for unmarried women (1,471) was 13 times higher than for married women (112) (Table 9). The large difference in abortion ratios between married and unmarried women does not take into account those women who conceived premaritally and who subsequently gave birth while married. This situation would tend to shift live births from the unmarried to the married category and thereby increase the abortion ratio for unmarried women and decrease the ratio for married women.

H. Number of Live Births

An inverse relationship existed between the woman's number of live births and the percentage of abortions obtained in 1978 (Table 10). Fifty-seven percent of abortions were obtained by women who had had no live births and 4% by women who had had 4 or more births (Summary Table). This represents a slight shift toward a lower parity--compared with 1977. Twenty-nine states in 1978 included the number of live births in their reports; these comprised 44% of all reported abortions.

Women with 1 live birth had the lowest abortion ratio (201) in 1978 and those with no births had the highest (446) (Table 10). Compared with 1977, there was an increase in the abortion ratio for women with 2 or fewer live births and a decrease for those with 3 or more (Figure 6).

I. Type of Procedure

In 1978 curettage (suction, sharp, and dilatation and evacuation) was the type of procedure used in 95% of abortions compared with 94% in 1977 (Summary Table). This represents a continuation of the shift toward curettage from other methods present since 1972. Thirty-seven states and the District of Columbia reported information on type of procedure in 1978, comprising 66% of all reported abortions (Table 11). Saline and prostaglandin instillation procedures made up 3% and 1%, respectively, a slight decline from 1977. Hysterotomy and hysterectomy accounted for 0.1% of all procedures in 1978, again a slight decline from 1977.

In states where instillation procedures were used, there was often a clear preference for 1 type of procedure over the other. For example, Kansas, Nebraska, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Virginia, and Washington used mainly saline, whereas Arkansas, Colorado, Hawaii, Montana, and Oregon used mainly prostaglandin.

J. Weeks of Gestation

In 1978 more than half (52%) of reported legal abortions were performed in the first 8 weeks of gestation (Summary Table). The majority (91%) of abortions were performed at less than 13 weeks' gestation. Approximately 4% of women obtained abortions in the 13- to 15-week interval and in the 16- to 20-week interval and only 1% at greater than 20 weeks. These proportions continue the trend noted since 1972 of an increase in the percentage of reported legal abortions performed at less than 9 weeks' gestation with a corresponding decrease in the percentage of abortions performed at later gestational ages (Summary Table). Although the proportion of abortions performed in the first and second trimesters remained the same in 1978 as in 1977, abortions were performed earlier in both trimesters (less than or equal to 8 weeks and 13-15 weeks, respectively). Thirty-seven states and the District of Columbia reported information on gestation at the time of abortion, comprising 66% of all reported abortions (Table 12).

K. Previous Induced Abortions

In 1978, 29% of abortions reported in 30 states and the District of Columbia were obtained by women who reported having had at least 1 previous induced abortion (Summary Table). Information on previous abortions was provided for 49% of all reported abortions in 1978 (Table 13). This continued the increasing trend toward repeated induced abortions reported for 1975 (18%), 1976 (20%), and 1977 (23%). Of the women who had abortions in 1978, 21% had had 1 previous abortion; 5% 2 abortions; and almost 2%, 3 or more. New York and the District of Columbia reported the highest level (34%) of women having had previous induced abortions; Nebraska had the lowest level (12%).

L. Weeks of Gestation by Type of Procedure

In 1978 curettage (suction and sharp) continued to be nearly the only method used (99%) for pregnancy termination in the first 12 weeks' gestation (Table 14). Thirty-two states reported information on weeks of gestation by type of procedure, accounting for 50% of all reported abortions in 1978. In the 13- to 15-week interval, 82% of all procedures were by curettage (dilatation and evacuation (D&E)), followed by saline instillation (10%) and prostaglandin instillation (4%). Saline instillation was the most commonly used method for both at 16-20 weeks' gestation (46%) and greater than or equal to 21 weeks (53%), with instillation of prostaglandin or other agents (e.g., urea) and D&E accounting for about 30% and 22%, respectively, in 1978. Compared with 1977, the percentage of saline instillation procedures used after 15 weeks' gestation decreased, D&E procedures increased, and instillation of prostaglandin and other agents remained the same. Since 1974, saline instillation after 15 weeks' gestation has decreased (from 72%), whereas D&E procedures and instillation of prostaglandin and other agents have increased.

M. Weeks of Gestation by Age Group

Younger women obtained abortions at later gestations than older women (Table 15). In 1978, 31 states reported data on weeks of gestation by age, accounting for 49% of all reported abortions. Over half the women in all age groups 20 or older obtained abortions in the first 8 weeks of gestation (Table 15). The tendency to obtain abortions at earlier gestational ages generally increased with the age of the woman, peaking in the 30- to 34-year-old age group. Almost 14% of abortions to women 19 years of age or younger occur after the first 12 weeks, compared with 7.4% of those to women 20 years or older. Women 19 years of age or younger appear twice as likely to obtain abortions after 16 weeks' gestation (7.3% compared with 3.7% for women 20 years of age or older) and account for almost half (46%) of the abortions performed after 16 weeks' gestation.

N. Weeks of Gestation by Race

A woman's race had relatively little impact on the gestational age when she obtained an abortion (Table 16). In 1978, 26 states reported information on weeks of gestation by race, accounting for 40% of all abortions. Women of black and other races were slightly less likely to obtain abortions in the first trimester and slightly more likely to obtain them after 16 weeks' gestation; however, these differences were less than 1.5% (Table 16).

O. Age Group by Race

Except for very young women, white women generally obtain abortions at younger ages than women of black and other races (Table 17). In 1978, 29 states reported information on age by race, accounting for 45% of all reported abortions. At all ages over 14 years, more than 68% of abortions were obtained by white women. Of the females 14 and younger who had abortions, over half (52%) were of black and other races, whereas of those 15-19 years old almost three-fourths (73%) were white. More women of black and other races (38%) were between 25 and 39 years of age when they obtained abortions than were white women (32%) in the same age group. In both racial groups--white and black and other--almost 2% of the women who had abortions obtained them after age 40.

P. Marital Status by Race

A woman's race was apparently unrelated to her marital status at the time she obtained an abortion (Table 18). In 1978, 29 states reported information on marital status by race, accounting for 41% of all reported abortions. The majority (73%) of women in both race categories were unmarried when they obtained abortions (Table 18).

Q. Interpretation

Since CDC began collecting information on legal abortion in 1969, the number of women who have had legal abortions has increased each year. In 1978 the total number of legal abortions reported to CDC rose 7% over the number reported in 1977. This was a lower percentage increase than in 1977. The abortion rate increased nearly 5%, approximately the same increase as reported for 1977; this was accompanied by a 2% decline in the United States fertility rate for 1978 (1). The abortion ratio increased nearly 7% in 1978, to 347 per 1,000 live births, a higher percentage increase than the 4% reported in 1977.

The number of abortions reported to CDC was probably less than the number actually performed in 1978. In public health surveillance, the number of reported cases is generally lower than the number obtained through surveys. In 1978, as in previous years, CDC's total was approximately 18% lower than the projected total obtained through the Alan Guttmacher Institute's nationwide survey of abortion facilities (2). The underreporting could produce some biases in the CDC data. Abortions performed in physician's offices are probably underreported more often than those performed in hospitals or other facilities (2). Since physicians probably perform abortions in their offices at earlier gestational ages of pregnancy than other facilities do, the underreporting of these data may bias the gestational age distributions toward the later stages of pregnancy.

The general availability of abortion services since 1973 has progressively allowed more women to obtain abortions within their state of residence. Since 1975 approximately 90% of women obtaining abortions have been able to have the procedures in their state of residence. The slight decrease in the proportion of in-state abortions in 1978 may reflect restrictions in public funding for abortion; restrictions would be expected to affect in-state abortions more than out-of-state procedures, since the latter do not qualify for public funding.

The age distribution of women obtaining abortions has shown a gradual shift from the group younger than 19 years of age to the 20- to 24-year age group, resulting largely from a similar shift in age distribution for women less than age 25 (3). In 1978 women at each end of the reproductive-age distribution had the highest abortion-to-live-birth ratio.

The proportion of abortions obtained by women of black and other races declined slightly for the first time since 1972. Although women of minority racial groups were still more likely to terminate pregnancy by abortion than were white women, their abortion ratio increased by a markedly smaller percentage.

Women of black and other races accounted for over half of the abortions obtained by the 14 and under age group. In part this higher percentage distribution may be because very young black teenagers are more likely to have sexual experience at an earlier age than their white counterparts (4). This is supported by an age-specific fertility rate 7 times higher for black and other teenagers in the 10- to 14-year age group than for white teenagers (1). In the 15- to 19-year age group, almost three-fourths of abortions are obtained by white teenagers. According to a recent survey, black teenagers are more likely to carry a pregnancy to term and less likely to put a child born out of wedlock up for adoption (5). A larger

proportion of black and other women in the 25- to 39-year age group obtain abortions than do white women.

In 1978 the proportion of abortions obtained by unmarried women declined for the first time since 1972. Several possible explanations exist: 1) funding restrictions may affect unmarried women to a greater extent than married women, 2) single women may have an increasing tendency to plan pregnancies which they wish to continue to term, and 3) reporting artifact. Although the fertility rate for unmarried black women was almost 6 times that of unmarried white women in 1978 (1), the proportion of unmarried women obtaining abortions was the same for both races. This may be partially due to an increased tendency for teenage black women to carry premarital pregnancies to term (5).

Women who have had no live births continued to account for an increasing proportion of abortions. Women with 3 or more births had a decline in the abortion ratio. Increasing use of the more effective contraceptive methods, primarily sterilization, may result in fewer unwanted pregnancies at these higher birth orders (6, 7).

Because the number of abortions has increased each year, the population at risk of having more than 1 abortion has increased. One would expect therefore that an increased percentage of abortions performed would be obtained by women who had undergone 1 or more previous procedures. This trend continued in 1978; 29% of abortions were obtained by women who had had at least 1 previous abortion, compared with 23% in 1977, 20% in 1976, and 18% in 1975.

In 1978, there was a continuation of the trend toward abortions at earlier gestational ages, which should have a favorable health impact by decreasing the morbidity and mortality associated with legally induced abortion procedures. Although the proportion of abortions obtained after 12 weeks' gestation remained the same as in 1977, a larger proportion was performed in the earliest interval (13-15 weeks) of the second trimester. This also would be expected to influence health parameters and may have contributed to the decreasing number of deaths from legal abortion.

III. ABORTION-RELATED MORTALITY

A. Surveillance Methods

In 1972 CDC began the epidemiologic surveillance of abortion-related mortality. The ultimate goal of the surveillance is to decrease the number of deaths from abortion by identifying factors which are amenable to change and which contribute to these deaths. In addition to reviewing such traditional factors as technical deficiencies in the provision of medical care, we also consider such nontraditional factors as community obstacles to health care and patient ignorance about sexuality, i.e., sociologic factors which may be amenable to public health intervention.

To find suspected or possible abortion-related deaths, we use several complementary methods, primarily vital statistics reports from state health departments. Of the subsequently confirmed abortion-related deaths from 1972-1978, 68% were reported through this vital statistics system. We also obtain reports from such sources as medical or hospital associations, maternal mortality committees, the National Center for Health Statistics, the Commission on Professional and Hospital Activities, published case histories, and incidental CDC investigations.

Our method of investigation consists first of confirming that a death occurred, then interviewing the attending physicians and reviewing all pertinent medical records. Where necessary, we also interview co-workers, relatives, and friends of the woman to ascertain nonmedical information such as the availability of medical services in the community, the means to pay for those services, and attitudes which may have interfered with appropriate use of medical services.

We continually update our abortion mortality statistics as we receive reports of deaths. The delay in reporting deaths to CDC has ranged from 1 hour to 6 years, with a median of 7 months. This report reflects the most current information available to CDC, and it updates previous Abortion Surveillance Reports and other CDC publications. As we learn of other abortion-related deaths, these will be included in subsequent publications. For the most current information on abortion-related deaths, interested persons should contact CDC directly rather than rely solely on published data.

B. Definitions

The Abortion Surveillance Reports of 1975-1977 described the process by which we established the definitions we used for abortion mortality surveillance. In the 1978 Abortion

Surveillance Report we have expanded these definitions to clarify their use in complex cases. A group of experts assisted in the process.*

1) Induced Abortion: A procedure (as contrasted with a complication) intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age. For this definition, the deciding factor is the intent of the procedure rather than its result. Thus, if the procedure failed to have any effect on the pregnancy, we would nevertheless consider it an induced abortion. Also, if the person performing the procedure were under the mistaken impression the woman had an intrauterine pregnancy with a living embryo or fetus, then we would consider the procedure an induced abortion, regardless of whether the woman in fact had an ectopic or molar pregnancy, or no pregnancy at all. However, if a molar pregnancy, ectopic pregnancy, or death of the fetus had already been diagnosed before any intervention, then we would not regard the procedure as an induced abortion.

We subcategorize induced abortions as "legal" or "illegal" as follows:

a) Legal abortion: A procedure performed by a licensed physician or someone acting under the supervision of a licensed physician.

b) Illegal abortion: A procedure performed by the woman herself, or by someone who was neither a licensed physician nor acting under the supervision of a licensed physician.

2) Spontaneous abortion: Either of the following types of complications of pregnancy, occurring before completion of the 20th menstrual week of gestation and not caused by an induced abortion:

a) Complete or incomplete expulsion of the products of conception from the uterus;

b) Failure of embryonic development or death of the fetus in utero, without any of the above complications.

We assume that these complications occurred spontaneously unless:

a) The woman admitted to someone that she had undergone an induced abortion; or

b) Physical or pathological examination of the woman revealed trauma to the reproductive tract suggestive of an induced abortion.

3) Unknown category of abortion: If we cannot obtain sufficient information to categorize an abortion using the above criteria, then we place it in the "unknown" category.

4) Abortion-related death: A death which resulted from a direct complication of an abortion, an indirect complication caused by the chain of events initiated by the abortion, or aggravation of a preexisting condition by the physiologic or psychologic effects of the abortion. To minimize the possibility of our failing to recognize an abortion-related death, we regard as abortion-related any death occurring within 42 days of an abortion, and any death resulting from an illness which began within 42 days after an abortion. Unlike traditional definitions of maternal death, which exclude deaths occurring beyond 42 days after the termination of pregnancy, we include as abortion-related any death which is attributable to abortion, regardless of how long it occurred after the abortion.

5) Ectopic pregnancy: Our review of abortion-related deaths since 1972 has identified 10 deaths from ectopic pregnancy occurring soon after an attempted legally induced abortion. In the 1978 Abortion Surveillance Report, we consider these deaths as abortion-related and include them as a separate subcategory of legally induced abortion (Figure 7). However, for analytic purposes, in our calculation of legally induced abortion death-to-case rates (Tables 19 to 23), these 10 deaths from ectopic pregnancy will not be aggregated with the other causes of death from legally induced abortion. The review panel felt that the pathophysiologic process leading to death from ectopic pregnancy was not causally related to either the woman's choice of induced abortion or the physician's choice of the abortion procedure. Thus, a woman who died from an ectopic pregnancy after an attempted curettage at 7 menstrual weeks' gestation would not be included in our aggregate analyses in either the "curettage" or the " 8 weeks' gestation" categories.

*William E. Brenner, M.D., Mark C.E. Cheng, M.D., Mary E. Converse, R.R.A., Irvin M. Cushner, M.D., Joseph H. Davis, M.D., Richard E. Dixon, M.D., John I. Fishburne, M.D., C. E. Gibbs, M.D., Sadja Greenwood, M.D., Perry A. Henderson, M.D., Lester T. Hibbard, M.D., Jane E. Hodgson, M.D., Irwin H. Kaiser, M.D, Richard H. Kaslow, M.D., Mary Grace Kovar, M.S., Sue Meads, Ervin E. Nichols, M.D., Ruth Roemer, J.D., Harold Schulman, M.D., Richard H. Soderstrom, M.D., Lee B. Stevenson, M.D., Steele F. Stewart, Jr., M.D., Phillip G. Stubblefield, M.D., Christopher Tietze, M.D., and Louise B. Tyrer, M.D.

C. Behavioral Risk Factors

In instances of abortion-related deaths we believe that the causal risk factors most likely to be preventable are those which involve voluntary behavior. We divide these behavioral risk factors into the following categories:

1) Patient factors: Inadequate use of contraception, delay in obtaining a legal abortion, and delay in obtaining medical care for an obvious complication.

2) Community factors: Unavailability of contraceptive services, legal abortion, or medical care of complications, and deterrents to the use of services, such as consent requirements which breach confidentiality.

3) Physician factors: Delay in diagnosis, delay in treatment, and use of relatively ineffective or hazardous methods of treatment.

4) Health-care facility factors: Deficient resources (drugs, equipment), inadequately skilled personnel, or policies which contribute to delayed or inadequate treatment (pertaining either to the facility that provides abortion services or to the facility that provides care for complications).

Unlike the "factors of responsibility" of traditional maternal mortality studies (described in the Abortion Surveillance Reports of 1975, 1976, and 1977), the behavioral risk factors described above do not necessarily involve any errors for which someone is to blame. On the contrary, the individuals or institutions concerned may behave as they do for reasons beyond their control. For example, a patient should not be blamed for her delay in obtaining medical services if this delay is caused by inability to pay for such services provided in her community. Neither should a physician be blamed for using an inferior method of treatment if the hospital in which he or she works lacks the equipment necessary to provide better treatment.

We have reviewed 106 abortion-related deaths that occurred in 1975-1977. From this review we have determined, for each category of abortion, the proportion of the deaths to which each behavioral risk factor contributed. In Table 24, we have presented the risk factors which contributed to at least 10% of the legal, illegal, and spontaneous abortion-related deaths.

The proportion of abortion-related deaths to which each behavioral risk factor contributed provides some measure of the effect of the risk factor on abortion mortality. It can thus help in identifying the particular factors which deserve priority in prevention. As can be seen in Table 24, the behavioral risk factors which contributed to the greatest proportion of legal and spontaneous abortion-related deaths involved the woman's delay in seeking medical care, either to obtain a legal abortion or for treatment of an obvious complication.

Patient factors, rather than physician factors, appear to be the behavioral factors which deserve priority in prevention. Many of the patient factors may be secondary to community factors, although we were unable to identify the latter in most of the deaths.

D. Total Abortion Mortality

Twenty-seven women died from abortion in 1978, 8 fewer than in 1977 (Figure 8). The fluctuation in the number of total abortion deaths in the last 3 years reflects variations within each of the 3 abortion categories--legally induced, illegally induced, and spontaneous. In 1978 the number of deaths after both legally induced and spontaneous abortions decreased, while the number after illegally induced abortions increased (Figure 7).

The inclusion of the 10 deaths between 1972 and 1978 from ectopic pregnancy after attempted legally induced abortion has increased both the total number of abortion-related deaths and those after legally induced procedures (see below). This accounts for most of the discrepancy between the total number of deaths reported in the current Abortion Surveillance Report and previous editions.

E. Legal Abortion Mortality

Eleven women died after legal abortions in 1978, compared with 17 in 1977, 11 in 1976, and 31 in 1975 (Figure 7). Of the 11 deaths in 1978, 4 were from ectopic pregnancy, compared with 2 of 17 in 1977, 0 of 11 in 1976, and 2 of 31 in 1975. Thus, the number of deaths from legally induced abortion excluding ectopic pregnancy contained in our aggregate analyses are 7 in 1978, 15 in 1977, 11 in 1976, 29 in 1975, 25 in 1974, 25 in 1973, and 24 in 1972. In 1978 a total of 1,157,776 legal abortions were reported to CDC. With this figure used as the denominator, the overall death-to-case rate for legal abortion (excluding ectopic pregnancy) was 0.6 per 100,000 abortions in 1978 (Table 19). This is not significantly different from the rate of 1.4 in 1977, and 1.1 in 1976 ($p > .05$, chi-square test). The death-to-case rates for legal abortion in 1976-1978 were significantly lower ($p < .01$) than those in earlier

years (3.4 in 1975, 3.2 in 1974, and 4.1 in both 1973 and 1972) (Table 19). Possible reasons for the decline after 1975 are: 1) the increasing percentage of abortions performed during the earlier, safer gestational ages, 2) increasing experience with abortion by practicing physicians, 3) the increasing percentage of abortions performed by safer methods, such as dilatation and evacuation (D&E), and 4) underreporting of legal abortion related deaths after 1975.

The aggregated data for the years 1972-1978 show that the risk of death from legal abortion was lowest for women whose abortions were performed at less than 9 menstrual weeks' gestation, with a death-to-case rate of 0.5 per 100,000 procedures (Table 20). The death-to-case rate increased by approximately 75%-100% for each week of delay after the eighth week through the 20th week. Abortions performed at 9-10 weeks were 2.8-fold more dangerous in terms of mortality than those performed earlier. Abortions performed at more than 20 weeks carried the greatest risk, with a death-to-case rate 35 times that of abortions performed at less than 9 weeks.

For purposes of categorizing deaths associated with particular abortion methods, we aggregated all procedures of suction curettage, sharp curettage, and D&E as instrumental evacuation procedures. These are subcategorized by gestational age at the time of abortion: procedures performed at less than 13 completed menstrual weeks of gestation are referred to as curettage procedures (including suction and sharp curettage), and those performed at 13 or more weeks' gestation are referred to as evacuation procedures (or D&E). Procedures which consist primarily of either hysterotomy or hysterectomy are referred to as hysterotomy/hysterectomy procedures.

For the years 1972-1978, mortality rates were highest for hysterotomy/hysterectomy abortions, and lowest for instrumental evacuation (including D&E), with instillation procedures intermediate (Table 21). Instrumental evacuation had a death-to-case rate of 1.3 per 100,000 abortions, compared with 12.5 for instillation, and 41.3 for hysterotomy/hysterectomy. Fifty-three women died from curettage procedures, 18 from D&E, 38 from saline instillation, 9 from prostaglandin instillation, 3 from use of other chemical abortifacients (e.g., urea, oxytocin), 9 from hysterotomy/hysterectomy, and 6 from other or unknown methods (Table 22).

Applying the type of procedure by weeks' gestation distributions from the reporting states (Table 14) to the total number of abortions reported from 1972-1978, we obtained denominators on which to calculate death-per-case rates specific for both procedure and gestation (Table 23). Because many states categorize prostaglandin instillation under the "other" category, for the purpose of this table we have had to group prostaglandin instillation with "other" methods in the denominator of the death-to-case rate for prostaglandin instillation. Deaths that occurred from other methods such as intrauterine insertion of rubber catheters were not included in the numerators of calculations for specific methods in the body of Table 23, but were included in the row labeled "total."

From 1972 through 1978, the risk of death due to instrumental evacuation procedures increased with gestational age. Curettage procedures had a death-to-case rate of 0.4 per 100,000 abortions at less than 9 weeks, 1.3 at 9-10 weeks, and 2.3 at 11-12 weeks; D&E procedures had a death-to-case rate of 5.6 per 100,000 abortions at 13-15 weeks, 14.1 at 16-20 weeks, and 13.5 at more than 20 weeks. Our data do not permit us to compare the risk of death from instrumental evacuation at 4-6 weeks with that at 7-8 weeks.

Although a woman's overall risk of dying is greater from D&E than it is from curettage procedures, it is significantly less ($p < .05$) than the risk from either of the 2 instillation procedures (last column, Table 23). From 1972-1978, D&E had an overall death-to-case rate of 7.7 per 100,000 abortions, compared with 13.9 for saline instillation and 9.0 for prostaglandin instillation (including other agents). The marked variation between prostaglandin and saline instillation within specific gestational age intervals is probably statistical artifact because of the relatively small number of deaths and cases involved. Moreover, denominators for calculating procedure-specific death-to-case rates among the instillation methods are distorted by categorization discrepancies among the different states reporting to CDC. Evaluated with the chi-square test, the death-to-case rates for various instillation methods at each gestational age are not significantly different ($p > .05$).

The following case history provides examples of behavioral factors contributing to the risk of death from legal abortion:

> Case History--A 26-year-old, divorced, white woman had had 1 previous pregnancy terminated by a legal abortion in 1972. She used oral contraceptives intermittently between 1972 and 1977, but because of side effects finally stopped using them entirely. She then tried an intrauterine contraceptive

device, but it was expelled. She subsequently used no method of contraception.

On December 20, 1977, she visited a medical clinic because of nausea, myalgia, and constipation. Physical examination revealed epigastric and right lower quadrant abdominal tenderness. Her last menstrual period began on November 10, 1977, almost 6 weeks previously, and a Gravindex pregnancy test was positive. On learning that she was pregnant, the woman immediately arranged for an abortion, which was performed on December 28. The woman underwent a suction curettage procedure with local anesthesia in an abortion clinic in a nearby metropolitan area. At this clinic the physicians did not routinely examine the products of conception except through the wall of the transparent suction tubing as tissue was aspirated from the uterus. The tissue was neither weighed nor examined in a watch glass with a dissecting scope. The aspirated material from all patients was collected together in a single bottle; therefore, it was unsuitable for patient-specific histopathologic examination. The procedure was uneventful, and the woman was told to expect lower abdominal cramps for a few days.

Two days later the woman began complaining of abdominal cramps, chills, and fever which persisted through the next day. Her roommate urged her to seek medical advice, but she refused. By the morning of January 2, 1978, she was extremely weak and was suffering from generalized pain, most marked in the abdomen and knees. Despite extreme pain and the proximity of a hospital across the road, she refused to seek medical care. She was in bed when her roommate left for work; when her roommate returned in the evening, she was dead.

Autopsy revealed 4,000 ml of blood in the peritoneal cavity and a ruptured ectopic pregnancy at the isthmus of the right fallopian tube. The fetal size was consistent with a 10 weeks' gestation.

The following behavioral factors contributed to the risk of death in the above case: 1) the woman was not using contraception when she conceived an unwanted pregnancy, 2) the woman's inadequate use of contraception was partly attributable to the community's failure to develop a reliable, acceptable contraceptive which was free from side effects, 3) routine procedures of the abortion clinic did not include an examination of the uterine aspirate to confirm products of conception in the appropriate quantity, 4) the abortion clinic staff told the woman to expect lower abdominal cramps, thus possibly contributing to her delay in seeking medical advice, and 5) the woman failed to seek medical advice despite obvious symptoms of illness or complication.

In this instance, the abortion increased the woman's risk of dying from a ruptured ectopic pregnancy because she was expecting symptoms, and thus failed to seek medical care appropriately. In similar cases, abortion procedures have contributed to death by leading physicians to misinterpret postabortal signs and symptoms as pelvic infection instead of ruptured ectopic pregnancy. Still other examples of deaths from ectopic pregnancy involve missed opportunities to diagnose an ectopic pregnancy, but are not abortion-related deaths because the abortion procedure itself does not increase the risk of death. This case emphasizes the importance of examining tissue removed from the uterus to confirm that it comprises the products of conception. This should be done before the woman leaves the abortion facility, because she may be impossible to contact afterwards, or the ectopic pregnancy may rupture before the pathology report is available. If products of conception are not found on initial or repeated curettage, the woman should be warned that she may have an ectopic pregnancy, and her condition should be further evaluated.

F. Illegal Abortion Mortality

Seven deaths were due to illegally induced abortion in 1978, an increase of 3 above the 4 reported in 1977 (Figure 7). We regard the number of deaths from illegal abortions as a reflection of the number of illegal abortions performed. The decline in the annual number of these deaths before 1977 probably reflected the increased availability of safer, legal procedures throughout the country, many of which were publicly funded.

In 1977 the Supreme Court ruled that states had the right to restrict the use of public funds for legal abortion services, and in August 1977 funds for abortion (mainly Medicaid funds) were restricted on the federal level. Over the next several months, 34 states similarly restricted state funds for abortion for Medicaid-eligible women. We have not detected a large increase in the number of deaths from illegal abortions resulting from these public policy decisions. The increase in 1977 and 1978 might be due to random fluctuation in the

occurrence of a rare event. However, the illegal abortions from which at least 4 women died during these two years may have been related to restricted public funds for legal abortions. One of these case histories was presented in the 1977 Abortion Surveillance Report. The case history of another woman, who died in 1978, is presented here:

Case History--A 21-year-old unemployed, single, black woman with a 5-year-old child resided with her father in a city of 350,000, in a state which had restricted public funds for legal abortions. There was only 1 publicly funded family planning clinic in the city, and a waiting period of several weeks was necessary for an appointment. The woman had only $10 in savings. Her contraceptive history is unknown.

In early May 1978 the woman recognized that she was pregnant. There were 3 abortion clinics in her city, but she could not afford the minimum charge of $150. In the second week of May, she inserted cotton-tipped swabs into her uterus to induce an abortion.

Over the next 2 weeks she had fever, chills, nausea, and diarrhea, which became increasingly severe. She was unable to eat or drink and became so weak that she was unable to walk. Finally, on June 5, 1978, her father took her to the family physician, who advised immediate hospitalization.

The woman had not yet told anyone that she might be pregnant. She told the admitting gynecology resident that she had fallen down 8 steps 2 weeks earlier and had passed blood and tissue from the vagina for 7 days. To a nurse, however, she confessed that she had attempted to induce an abortion because of financial hardship.

When she was admitted to the hospital, physical examination revealed a temperature of 105.6 F, pulse 108/min, respirations 34/min, blood pressure 150/70, and diffuse tenderness and guarding in the lower abdomen. The uterus was enlarged, but its size could not be accurately measured because of guarding. The cervix was soft, dilated, and tender to motion. There was no active bleeding. All other physical findings were normal. Laboratory results revealed anemia, with a hemoglobin of 8.3 gm/dl, hematocrit 24.2%, and white blood cell count of 7,100, with the differential count shifted to the immature side. Serum sodium was only 134 mEq/l, but blood urea nitrogen was elevated to 25 mg/dl. Results of chest x-ray were normal. The admission diagnosis was septic abortion with anemia and dehydration.

Bacteriologic cultures of blood and endometrium were obtained, and the patient was treated with massive doses of penicillin, gentamicin, and chloramphenicol intravenously. She received a transfusion of 2 units of blood. The following day she underwent a curettage of the uterus, and necrotic fragments of placenta were removed. She remained febrile, with temperature rising as high as 106.7 F. For a presumptive diagnosis of septic pelvic thrombophlebitis, she was given heparin and corticosteroids intravenously.

Despite treatment, the patient's vital signs remained highly elevated (temperature 102-106 F, pulse 120-140/min, respirations 40-60/min). Chest x-ray findings suggested pulmonary embolism. Because a pelvic abscess was suspected, on June 8, 1978, the patient underwent exploratory laparotomy. No intra-abdominal abscess was found, but ligation of the inferior vena cava and left ovarian vein was performed to try to prevent further pulmonary embolism.

Over the next 2 weeks the patient remained febrile. Multiple lung abscesses developed, and pulmonary function deteriorated. Medical consultants recommended a repeat laparotomy to search for a pelvic abscess. This was done on June 15, 1978, and again no pelvic abscess was found. A supracervical hysterectomy was performed to remove any possible nidus of infection in the uterus. The patient had a cardiac arrest during the procedure and could not be resuscitated.

Autopsy revealed multiple lung abscesses and empyema on the right side. Culture of the pus grew Bacteroides species. The examination of the uterus showed endometritis.

This case illustrates several characteristic behavioral factors which contribute to the risk of death from an illegal abortion: 1) the community in which the woman resided did not provide adequate family planning services, 2) the community did not subsidize legal abortion services for poor women, and this reduced the alternatives available to her, leading the woman to attempt self-induced illegal abortion, 3) the woman delayed seeking medical care for an obvious illness (possibly because she lacked money or feared criminal prosecution for the abortion), 4) the woman initially hid the fact that she had induced abortion from the admitting physician, thereby leading to a further delay in treatment, and 5) the physician delayed emptying the uterus (for a day) after diagnosing a septic abortion.

Table 14
Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure,* 1978

Weeks of Gestation	Type of Procedure					
	Curettage	Intrauterine Saline Instillation	Intrauterine Prostaglandin Instillation	Hysterotomy/ Hysterectomy	Other	Total
≤ 8	51.6 (98.9)	1.6 (0.1)	1.3 (0.0)	31.4 (0.1)	30.0 (0.9)	49.2 (100.0)
9-10	29.5 (99.1)	2.1 (0.2)	1.6 (0.1)	17.2 (0.1)	10.2 (0.6)	28.1 (100.0)
11-12	13.8 (97.2)	4.3 (0.9)	3.8 (0.3)	14.2 (0.1)	12.4 (1.4)	13.4 (100.0)
13-15	3.9 (82.1)	15.0 (10.0)	16.9 (4.3)	13.1 (0.3)	9.3 (3.3)	4.4 (100.0)
16-20	1.0 (24.6)	59.6 (45.6)	63.2 (18.7)	20.3 (0.5)	26.4 (10.6)	3.9 (100.0)
≥ 21	0.1 (12.8)	17.4 (52.8)	13.2 (15.4)	3.8 (0.4)	11.7 (18.6)	1.0 (100.0)
Total	100.0 (94.3)	100.0 (2.9)	100.0 (1.1)	100.0 (0.1)	100.0 (1.5)	100.0 (100.0)

*Based on data from 32 states

Table 20

Death-to-Case Rate for Legal Abortions, by Weeks of Gestation, United States, 1972-1978

Weeks of Gestation	Deaths[1]	Abortions[2]	Rate[3]	Relative Risk[4]
≤ 8	13	2,749,725	0.5	1.0
9-10	24	1,705,478	1.4	2.8
11-12	20	883,932	2.3	4.6
13-15	20	300,186	6.7	13.4
16-20	47	338,488	13.9	27.8
≥ 21	12	68,584	17.5	35.0
Total	136	6,046,393	2.2	

[1]Excludes deaths from ectopic pregnancy
[2]Based on distribution of 4,292,615 abortions (71.0%) with weeks of gestation known
[3]Deaths per 100,000 abortions
[4]Based on index rate for ≤8 menstrual weeks' gestation of 0.5 per 100,000 abortions

Table 21

Death-to-Case Rate for Legal Abortions, by Type of Procedure, United States, 1972-1978

Type of Procedure	Deaths[1]	Abortions[2]	Rate[3]	Relative Risk[4]
Instrumental evacuation	71	5,550,874	1.3	1.0
Intrauterine instillation	50	400,315	12.5	9.6
Hysterotomy/ Hysterectomy	9	21,810	41.3	31.8
Other[5]	6	73,394	8.2	6.3
Total	136	6,046,393	2.2	

[1]Excludes deaths from ectopic pregnancy
[2]Based on 4,334,991 abortions (71.7%) with type of procedure known
[3]Deaths per 100,000 abortions
[4]Based on index rate for instrumental evacuation of 1.3 per 100,000 abortions
[5]Includes 2 deaths with type of procedure unknown

Table 22
Legal Abortion Deaths* by Type of Procedure
and Weeks of Gestation, United States, 1972-1978

Type of Procedure	Weeks of Gestation ≤ 8	9-10	11-12	13-15	16-20	≥ 21	Total
Curettage	12	22	19				53
Dilatation and evacuation				10	7	1	18
Instillation				5	36	9	50
(Saline)				(1)	(31)	(6)	(38)
(Prostaglandin)				(3)	(5)	(1)	(9)
(Other agents)				(1)	(0)	(2)	(3)
Hysterotomy/ Hysterectomy	0	2	1	3	2	1	9
Other[1]	1	0	0	2	2	1	6
Total	13	24	20	20	47	12	136

[1]Includes 2 deaths with unknown type of procedure, 1 at 13-15 weeks and 1 at 16-20 weeks of gestation

*Excludes deaths from ectopic pregnancy

Table 23
Death-to-Case Rate* for Legal Abortions,
by Type of Procedure and Weeks of Gestation
United States, 1972-1978

Type of Procedure	Weeks of Gestation ≤ 8	9-10	11-12	13-15	16-20	≥ 21	Total
Curettage	0.4	1.3	2.3				1.0
Dilatation and evacuation				5.6	14.1	13.5	7.7
Instillation	0.0	0.0	0.0	8.2	14.2	19.5	12.3
(Saline)	(0.0)	(0.0)	(0.0)	(2.2)	(17.6)	(17.1)	(13.9)
(Prostaglandin and other agents[1])	(0.0)	(0.0)	(0.0)	(24.8)	6.4)	(26.7)	(9.0)
Hysterotomy/ Hysterectomy	0.0	55.5	37.2	68.3	45.2	147.3	42.8
Total[2]	0.4	1.4	2.4	8.2	15.2	22.1	2.2

[1]Denominators for rates include abortions reported as type of procedure "other" (1% of all abortions with procedure known)
[2]Includes deaths with type of procedure "other" (4) and unknown (2)

*Deaths per 100,000 abortions; based on distributions of abortions with type of procedure and weeks of gestation known

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Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities

WILLARD CATES, Jr, MD, MPH, AND DAVID A. GRIMES, MD

In 1978, dilatation and evacuation (D & E) became the leading method of abortion at 13 weeks' gestation or later in the United States. The increasing popularity of D & E reflects its relative advantages in safety, convenience, expense, and speed when compared with alternate methods. The authors reviewed all reported deaths from D & E in the United States between January 1, 1972, and December 31, 1978. The predominant causes of death were infection and hemorrhage. Both race and gestational age significantly influence the death:case rate for D & E procedures. White women had a threefold lower risk of dying from D & E than women of other races. D & E procedures performed at 13 to 15 weeks' gestation were nearly 3 times safer than those performed at 16 weeks or later. D & E performed in nonhospital settings did not have higher death:case rates than those performed in hospitals. Comparative mortality data suggest abortion by D & E at 13 weeks' gestation or later is more dangerous than suction curettage performed earlier in gestation, but safer than instillation techniques performed later. The advantage of D & E occurs largely in the 13- to 15-week gestation interval, that is, at the beginning of the second trimester. Policy makers should reconsider laws requiring all second trimester abortions to be performed in hospitals. Based on these data, 16 weeks' gestation would be a more appropriate threshold at present. *(Obstet Gynecol 58:401, 1981)*

From the Abortion Surveillance Branch, Family Planning Evaluation Division, Centers for Disease Control, Atlanta, Georgia.
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Dilatation and evacuation (D & E) has emerged as the leading method of second trimester abortion in the United States. In 1978, D & E accounted for 51% of all abortions at 13 weeks' gestation or later.[1] Over three quarters (77%) of D & E procedures are performed in the 13- to 15- week gestation interval, although 20% are performed in the 16- to 20-week interval, and 3% at 21 weeks' gestation or later.[1]

The increased popularity of D & E for second trimester abortion reflects its relative advantages in safety, convenience, expense, and speed when compared with alternate methods.[2] Over the past 6 years, numerous case series,[3-12] prospective observational studies,[13-19] and 1 randomized clinical trial[20] have documented the superiority of D & E to other second trimester procedures.

Despite these reported advantages, some authorities believe that widespread use of D & E by physicians inexperienced in this technique may increase the risks of the procedure.[21] Others believe that second trimester D & E is so risky that it should only be performed in hospitals.[22] They predict that increasing use of D & E in nonhospital facilities will cause an increase in the incidence of deaths and complications.

This article reviews all reported deaths from D & E in the United States between January 1, 1972, and December 31, 1978. The causes of these deaths are criti-

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cally examined, and suggestions are offered to prevent them. The death:case rates for D & E and other second trimester procedures are compared, and, finally, the risk of death from D & E procedures performed in hospital and nonhospital settings is determined.

Methods

Abortion-related deaths were identified through the Centers for Disease Control's ongoing surveillance of abortion mortality, the methods of which have been described in detail previously.[1] D & E procedures are defined as those transcervical evacuation methods performed at 13 menstrual weeks' gestation or later. These procedures frequently involve using a combination of instruments: vacuum equipment, a sharp curette, and special forceps.[2] Gestational age for each procedure in which a woman died was determined by postoperative measurements of fetal size,[23,24] rather than by less objective preoperative estimates. Using these postoperative objective measures, the duration of gestation is expressed as completed menstrual weeks throughout the report.

The Centers for Disease Control's annual abortion surveillance activities[1] provided denominators for the death:case rates. The type of procedure was cross-tabulated by gestational age from those states that reported these data, and was applied to the total number of second trimester abortions reported in the period from 1972 to 1978. The age and race distributions for women obtaining D & E procedures were assumed to be the same as those for all women obtaining second trimester abortions.

Since data supplied to the Centers for Disease Control do not include numbers of abortions by type of abortion facility, this information was obtained from the annual surveys of providers of abortion services conducted by the Alan Guttmacher Institute.[25-27] In these surveys a nonhospital clinic was defined as a facility that was not physically connected to a hospital and that was organized to provide abortions and medical services on an ambulatory patient basis. Abortions performed on an outpatient basis in hospitals or hospital-based clinics were categorized as hospital abortions. For deaths after D & E procedures, these definitions were used to categorize the facility in which the abortion was performed.

The Alan Guttmacher Institute collected information by the type of facility in which second trimester abortions were performed for only the years 1976 through 1978. To obtain estimates for 1972 through 1975, the linear regression curve derived from the known second trimester facility distributions (ie, 1976 to 1978) was applied to the unknown distributions (ie, 1972 to 1975). Because instillation procedures generally terminate inside hospitals, all second trimester abortion procedures performed in nonhospital facilities were further assumed to be by D & E.

Because the relatively small number of deaths limited the authors' statistical extrapolations, 95% confidence limits for the death:case rates were calculated. From the Poisson distribution,[28] the 95% confidence limits were applied to the numerator (the number of deaths); these numbers were then divided by the estimated denominators (numbers of abortions) to derive the 95% upper and lower bounds of the death:case rates.

Case Reports

Eighteen women died in the period from 1972 to 1978 from second trimester D & E abortions (Table 1). The women's ages ranged from 16 to 37 years; 11 were black, 6 were white, and 1 was Hispanic. Three were primigravidas. Ten were in the 13- to 15-week gestational age interval, 7 in the 16- to 20-week interval, and 1 had a gestational age greater than 20 weeks. Of the 18 women, 12 had preexisting conditions that either hindered the preoperative evaluation or contributed to the death. In 8 cases, gestational age was underestimated by at least 4 weeks.

Eleven women died after having D & E procedures performed in nonhospital clinics, and 7 women died after having procedures performed in hospitals. In 5 of the deaths, a delay of more than 24 hours occurred between the onset of the woman's initial postabortion symptoms and her eventual referral by the physician to a hospital.

The predominant causes of death were infection and hemorrhage. Eight infections were secondary to incomplete evacuation of the uterine contents (Table 1). In 5 of these 8 cases, the physician had underestimated the gestational age by 4 weeks or more. Seven women died from hemorrhage, 5 of which cases were caused by uterine perforation. The 3 other causes of death were a toxic reaction after paracervical anesthesia, a pulmonary thromboembolism 4 weeks after the abortion, and a suicide by carbon monoxide inhalation.

Death:Case Rates

In the United States for the 7 years between 1972 and 1978, D & E methods had an overall death:case rate of 7.7 per 100,000 procedures (Table 2). Age had little effect on the risk of dying from D & E. Women over 30 had a slightly higher death:case rate than younger women, but the difference was small and not statistically significant ($P > .30$).

However, both race and gestational age significantly influenced the death:case rate for D & E procedures. White women had a threefold lower risk than women of other races of dying from D & E. D & E procedures

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Table 1. Deaths Associated with Dilatation and Evacuation in the United States Between 1972 and 1978

Case no.	Age	Race	Parity	Gestation (wk)		Preexisting conditions	Facility	Cause of death
				Estimated	Actual			
Infection								
1	27	W	G-1 P-0	12*	16	Obesity, abdominal scar	Clinic	Peritonitis and septic shock from incomplete evacuation
2	23	B	G-2 P-1	13	13	Obesity, recent PID	Hospital	Peritonitis and septic shock from uterine perforation and incomplete evacuation
3	19	W	G-1 P-0	8*	15	None	Hospital	Peritonitis and septic shock from incomplete evacuation
4	16	B	G-2 P-1	12*	16	None	Clinic	Peritonitis and septic shock from incomplete evacuation
5	18	B	G-2 P-1	12*	17	Obesity	Clinic	Peritonitis and septic shock from incomplete evacuation
6	23	B	G-2 P-1	9*	13	None	Clinic	Peritonitis and septic shock from incomplete evacuation
7	16	W	G-2 Ab-1	17	17	Unrecognized ventricular septal defect	Hospital	Acute bacterial endocarditis of aortic valve and ventricular septum causing acute congestive heart failure 2 wk after the abortion
8	16	B	G-1 P-0	20	20	None	Clinic	Septic shock and adult respiratory distress syndrome after amnionitis and endometritis
Hemorrhage								
9	37	B	G-4 P-3	8*	14	Obesity	Clinic	Hypovolemic shock caused by hemorrhage after incomplete evacuation
10	32	B	G-6 P-3 Ab-2	14	14	Obesity, anemia	Hospital	Hypovolemic shock caused by hemorrhage from cervical and uterine perforation
11	26	B	G-6 P-3 Ab-2	17	17	Anemia	Hospital	DIC and hypovolemic shock caused by hemorrhage from uterine perforation
12	29	H	G-5 P-4	12*	21	Previous cervical laceration	Clinic	Hypovolemic shock caused by hemorrhage from cervical and uterine perforation
13	18	W	G-3 P-2	11*	16	None	Clinic	Hypovolemic shock caused by hemorrhage from uterine perforation
14	34	B	G-7 P-6	14	14	Obesity, sarcoidosis, hypertension, concurrent tubal ligation	Clinic	Hypovolemic shock caused by hemorrhage from uterine perforation
15	25	B	G-5 P-3 Ab-1	14	14	Previous hemorrhagic diathesis after suction curettage	Hospital	DIC and pulmonary hemorrhage occurring immediately after completion of dilatation and evacuation
Other								
16	20	B	G-2 P-1	12	14	None	Clinic	Cardiovascular collapse from toxic reaction to paracervical anesthesia
17	26	W	G-3 P-1 Ab-1	14	14	Past thrombophlebitis on oral contraceptives	Clinic	Pulmonary thromboembolism 4 wk after abortion
18	19	W	G-2 P-0 Ab-1	14	14	Suicidal threats, sociopathic personality	Hospital	Suicide by carbon monoxide inhalation 4 days after abortion

LMP = last menstrual period; W = white; B = black; H = hispanic; G = gravidity; P = parity; Ab = abortus; PID = pelvic inflammatory disease; DIC = disseminated intravascular coagulation.

* Discrepancy of 4 weeks or more between the preoperative estimate and actual gestational age.

Table 2. Death : Case Rates for Dilatation and Evacuation Procedures, by Woman's Age, Race, Weeks' Gestation, and Type of Facility in the United States Between 1972 and 1978

Characteristic	No. of deaths	Estimated no. of procedures	Death : case rate*
Woman's age			
≤ 19	7	103,100	6.8 (3–14)
20–29	8	105,400	7.6 (3–15)
≥ 30	3	25,800	11.6 (2–34)
Race			
White (including Hispanic)	7	154,700	4.5 (2–9)
Black and other	11	79,600	13.8 (7–25)
Gestational age (wk)			
13–15	10	177,300	5.6 (3–10,
≥ 16	8	57,000	14.0 (6–28)
Type of facility			
Clinic	11	160,200	6.9 (3–12)
Hospital	7	74,100	9.4 (4–20)
Total	18	234,300	7.7 (5–12)

* Deaths per 100,000 procedures. The 95% confidence limits are in parentheses.

performed at 13 to 15 weeks' gestation were nearly 3 times safer than those performed at 16 weeks or later. Apparently these 2 factors were not interrelated, as 7 of the 10 women of black and other races who died after D & E had their procedures performed at 13 to 15 weeks' gestation; thus, the relative difference in death : case rates between white and nonwhite women was greater at 13 to 15 weeks than at later gestational ages.

D & Es performed in nonhospital settings had lower death : case rates than those performed in hospitals (Table 2). However, for reasons elucidated below, these differences should be interpreted cautiously.

When D & E was compared with other abortion methods, its death : case rate was found to be higher than that of curettage procedures performed earlier in gestation, but lower than rates of the other second trimester alternatives (Table 3). The death : case rates were 1.0 per 100,000 procedures for curettage abortions performed at 12 weeks' gestation or earlier; 12.3 for second trimester instillation procedures; and 42.8 for hysterotomy/hysterectomy procedures. However, because the risk of death from D & E is directly related to gestational age, the death : case rate in the 13- to 15-week interval (5.6/100,000) is significantly ($P < .05$) less than at 16 weeks' gestation or later (14.0/100,000). Thus, the lower risk of dying from D & E compared with instillation techniques appears primarily related to the comparative advantages of D & E in the 13- to 15-week period.[29] After 15 weeks' gestation, the death : case rates for D & E and instillation agents are quite similar (Table 3).

Discussion

Comparative Risks

The death : case rates for D & E in the United States are consistent with British data. In the 6 years between 1968 and 1973, Great Britain reported a fatality rate for D & E of 6.6 per 100,000 procedures,[30] compared with 7.7 per 100,000 in the United States. This similarity between American and British death : case rates for D & E procedures suggests that these data accurately portray the risk of death from the procedure.

Although age was not a factor influencing the risk of dying from D & E, race was. Women of black and other nonwhite races had death : case rates 3 times higher than those of white women. Moreover, controlling for gestational age widened this apparent difference between the 2 racial groups. The increased risk of complications and death from abortion and other pregnancy-related events for women of black and other races has been reported in previous articles.[31,32] Race may represent the influence of economic status, and these numbers may reflect differences in medical care received by different income groups.

Table 3. Death : Case Rates by Type of Abortion Method and Gestational Age in the United States Between 1972 and 1978

Type of method and gestational age	No. of deaths	Estimated no. of procedures	Death : case rate*	95% CL†
D & E (≥ 13 weeks)	18	234,300	7.7	5–12
13–15 weeks	10	177,200	5.6	3–10
≥ 16 weeks	8	57,000	14.0	6–28
Curettage (≤ 12 weeks)	53	5,385,200	1.0	0.7–1.3
Instillation (≥ 13 weeks)	50	405,900	12.3	9–16
Saline	38	273,000	13.9	10–19
Prostaglandin and other agents	12	132,900	9.0	5–16
Hysterotomy/hysterectomy	9	21,000	42.8	20–81

* Deaths per 100,000 procedures.
† 95% confidence limits.

For any abortion performed by uterine evacuation techniques, gestational age is the most important variable affecting risk. Previous investigations of abortion morbidity have shown that complications after D & E in the second trimester are both more frequent and more severe than after first trimester curettage procedures.[2] The data on abortion mortality demonstrate that D & E at 13 weeks' gestation or later carries higher risks of dying than uterine evacuation procedures performed earlier in gestation; moreover, D & E procedures performed earlier in the second trimester are safer than those performed later.

The other available second trimester abortion techniques had higher aggregate death:case rates than did D & E, largely due to the comparative advantage of D & E in the 13- to 15-week gestational age interval. Beyond 15 weeks, the risks of death from D & E and instillation procedures are similar. Since comparative mortality data do not differentiate among abortion procedures at 16 weeks' gestaton or later, perhaps other factors, such as cost, convenience, psychologic impact on the woman, psychologic impact on the staff, and risk of long-term complications, play a greater role than short-term safety in choosing the appropriate method.[2]

Preventing Deaths from D & E

This analysis of the causes of death suggests several approaches to reduce the risk of dying after D & E: 1) perform D & E procedures earlier in the second trimester; 2) determine gestational age as accurately as possible; 3) use laminaria or other gradual methods for preoperative dilatation; and 4) refer women with suspected complications to facilities equipped to manage the complications.

As emphasized above, the risks of D & E increase as the pregnancy progresses. Thus, as with all instrumental evacuation procedures, the earlier the D & E is performed the better. Anything that contributes to delay in performing abortions increases the complication rates by 15 to 30%,[33,34] and the chance of dying by 50%[32] for each week of delay. Because the risks of morbidity and mortality with D & E are higher than with suction curettage, the marginal increase in risk from the same amount of delay is even greater for D & E. Thus, for example, the risks imposed by a mandatory 72-hour waiting period for an abortion are quite small for early suction curettage procedures, but are magnified for later second trimester D & E.

Accurate assessment of gestational age before performing D & E may also lower risks. In 5 of the 8 infection deaths and 3 of the 7 hemorrhage deaths, physicians had underestimated the true length of gestation. This inaccuracy could have led to incomplete abortion or perforation of the uterus during attempts to remove fetal parts through an inadequately dilated cervix. One study of uterine perforation has documented that misestimation of uterine size contributes to the risk of perforation.[35] Moreover, the highest rate of reported uterine perforation with D & E was in a study that involved a discrepancy between the preoperative and postoperative estimates of gestational age.[11]

Seven of the 8 deaths in which physicians had underestimated the length of gestation occurred in clinics. In part, this may have represented a deliberate misestimate in order to conform with state laws requiring second trimester abortions in hospitals. Alternatively, unintentional underestimation also can occur with even experienced clinicians.[11] To reduce errors, some physicians obtain preoperative sonograms on all patients in the second trimester to confirm gestational age, whereas others use this technique only when there is a discrepancy between menstrual dates and uterine size estimations. Although accurate determination of length of gestation might reduce complications and deaths from D & E, routine use of sonography increases both the cost and inconvenience of the procedure.

Use of laminaria or other gradual methods for preoperative cervical dilatation before evacuation may also reduce the risk of cervical injury, uterine perforation, and retained tissue, all of which have contributed to hemorrhage, infection, and eventual death. Wider dilatation is usually necessary to remove uterine contents at later gestational ages. Laminaria,[36] balloon devices,[37] and prostaglandin suppositories[38] have been used to achieve slower, more "physiologic," dilatation than mechanical dilators. However, like sonography, use of these methods increases the cost and inconvenience to the woman.

Because complications after D & E procedures are both more frequent and more severe than those after curettage procedures earlier in gestation,[2] clinicians should refer women with suspected complications promptly. Unfortunately this has not always been the case. In at least 5 of the deaths in the present study, women were not referred promptly for conditions requiring immediate evaluation and treatment unavailable in the original facilities. Some physicians delayed referral because they feared criticism from their colleagues for performing unconventional D & E procedures. Others were afraid of prosecution. In those states that require that all abortions later than 12 weeks' gestation be performed in hospitals, clinicians were reluctant to admit that they had inadvertently initiated an abortion in a nonhospital facility on a

woman beyond the legal gestational age. Fearing both rejection by their colleagues and prosecution by law enforcement officials, these physicians were hesitant to send their patients to a hospital for further treatment. In these situations, the abortion regulations requiring hospitalization in the second trimester hindered rapid and appropriate care.

D & E Procedures in Hospital or Nonhospital Facilities

The crude death:case rate for D & E procedures performed in nonhospital facilities was lower than that for D & E performed in hospitals. However, these differences must be viewed cautiously for several reasons: 1) the small number of deaths involved does not allow statistical differentiation at the traditional level of .05; 2) selective underreporting of deaths from either nonhospital or hospital facilities may have occurred; 3) as described previously, the denominators are estimates based on challengable assumptions; yet, when only those procedures performed between 1976 and 1978 were analyzed, the same difference in death:case rates between hospitals and nonhospitals still appeared; 4) women having abortions in nonhospital clinics may be different from women having their procedures performed in hospitals. For example, women who are not hospitalized for abortions may be healthier or may have had their procedures performed earlier in the second trimester.

Many of these factors would spuriously raise the death:case rate for D & E performed in hospitals compared with those performed in nonhospital facilities. For example, the authors' previous comparisons[39,40] of the risk of dying from suction curettage procedures at 12 weeks' gestation or earlier showed higher crude death:case rates for hospitals; however, after controlling for preexisting conditions and concurrent sterilization, the differences disappeared. Moreover, it is likely that D & E in clinics may be performed earlier in the second trimester than those performed in hospitals.[41] Thus, whether D & Es can be performed more safely in nonhospital facilities cannot be determined from the available data.

Some clinicians emphasize that deaths from D & E could have been prevented if the procedure had been performed in hospitals rather than in clinics. For example, the 4 women who died from internal hemorrhage after uterine perforation in a nonhospital facility might have benefited from immediate availability of blood bank services. Yet, performing D & E procedures in hospitals does not provide complete protection; 3 of the 7 deaths from hemorrhage after D & E occurred in hospitals with blood banks.

These data do not support regulations in some states requiring all second trimester abortions to be performed in hospitals. These laws were encouraged by the Supreme Court's decision on abortion in 1973, which allowed states to regulate second trimester abortions in the interests of the woman's health. Data forming the basis for this decision were collected before 1972, when the available second trimester methods were primarily saline instillation and hysterotomy.[42] Since 1973, however, abortion techniques have improved, physicians have accumulated greater experience, and the concept of trimester threshold for uterine evacuation procedures has been largely abandoned. Case series[10,11] have demonstrated that some physicians can safely perform D & E in nonhospital facilities, thus decreasing the cost and increasing the convenience for the woman. The comparative mortality data indicate that performing D & E outside of hospitals carries no greater risk of death. Thus, it is time to reconsider restrictive regulations that have not kept pace with medical practice.

Recently, judicial decisions in some states have redefined their upward gestational age limit for performing second trimester abortions outside of hospitals.[43] New Jersey, North Carolina, Louisiana, Wisconsin, and Missouri allow abortions up through 16 weeks' gestation in nonhospital facilities. However, decisions in Ohio and Indiana have upheld the validity of requiring that all second trimester abortions be performed in hospitals. As of now, 16 states still maintain laws or regulations with a second trimester hospitalization requirement.[44]

The data do not identify the appropriate gestational age limit for requiring that all abortions be performed in hospitals. One practitioner has reported safely performing D & E through 20 weeks' gestation in nonhospital settings.[10] To require this physician to perform his procedures in hospitals might only increase the costs without improving the safety. However, as a general rule, it is reasonable to perform procedures with death:case rates of approximately 10/100,000 or less outside the hospital; this level of risk would include such common procedures as tonsillectomy, laparoscopic tubal sterilization, and diagnostic dilatation and sharp curettage.[45] For D & E, this would permit moving the threshold for required hospitalization from 12 to 16 weeks' gestation. As abortion techniques and physicians' skills improve further, the threshold could be slowly advanced. Proposed changes should be based on scientific evidence gathered through ongoing surveillance, however, rather than on unsubstantiated opinions.[45]

Moreover, because the risks of D & E are greater than those of suction procedures performed at an ear-

lier gestational age, certain prudent approaches are recommended for those nonhospital facilities wishing to perform outpatient abortions beyond 12 weeks' gestation: 1) the physician should be thoroughly experienced in first trimester curettage procedures; 2) the physician should advance cautiously the gestational age threshold as experience is gained with the uterine evacuation procedures performed later in gestation; 3) the facilities should agree to monitor their patients closely and to report complication rates regularly to state or local health authorities; 4) the facilities should agree to be inspected when necessary by professional colleagues; 5) the facilities must provide continued availability of postoperative care on a 24-hour basis; and 6) arrangements for emergency care should be established with hospitals near the nonhospital facility.

In conclusion, comparative mortality data suggest abortion by D & E at 13 weeks' gestation or later is more dangerous than suction curettage performed earlier in gestation, but safer than instillation techniques performed later. The advantage of D & E occurs largely in the 13- to 15-week gestation interval. Policy makers should reconsider laws requiring all second trimester abortions to be performed in hospitals. Based on these data, 16 weeks' gestation would be a more appropriate limit for nonhospital abortions at the present time.

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Address reprint requests to:
Willard Cates, Jr, MD, MPH
Centers for Disease Control
Center for Health Promotion and Education
Family Planning Evaluation Division
Atlanta, GA 30333

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Document #4

Mortality From Abortion and Childbirth

Are the Populations Comparable?

Scot A. LeBolt; David A. Grimes, MD; Willard Cates, Jr, MD, MPH

• **Critics have challenged previous comparisons of mortality from legal abortion and childbirth for contrasting population groups with different clinical characteristics. They allege that most women dying from abortion were young, white, and healthy, while those dying from childbirth had serious underlying conditions. To address this question, we calculated standardized abortion and childbirth mortality rates between 1972 and 1978. We also adjusted independently for preexisting medical conditions. These adjustments for demographic and health differences between the two populations actually widened the difference in the mortality risk between abortion and childbirth. Thus, between 1972 and 1978, women were about seven times more likely to die from childbirth than from legal abortion, with the gap increasing in the more recent years.**

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OUR COMPANION article (p 192) addresses the issue of whether the crude data comparing mortality from legal abortion and childbirth for the woman contained statistical biases favoring the safety of abortion; we conclude they did not. Rather, the crude data between 1972 and 1978 appear to overestimate the abortion risks for the woman, compared with the risks of childbirth.

See also p 192.

However, another separate allegation by some critics[1,2] is that the populations of women dying from either abortion or childbirth are not clinically comparable. These critics claim that most women who died from abortion were young, white, and healthy and that those who died from continuing their pregnancies to term had serious underlying medical conditions. We undertook this study to address this question and also to update our previous data.[3,4] In this report we present standardized abortion and childbearing mortality rates between 1972 and 1978. We also adjusted independently for the presence of preexisting conditions. These more recent data corroborate that, in terms of risk of death, abortion is safer than childbearing.

From the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta.

Reprint requests to the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta, GA 30333 (Dr Grimes).

METHODS

The various sources of data for comparing mortality from legal abortion and childbearing are described in detail in the companion article (p 192). For this analysis, we used the number of abortion-related deaths from the Centers for Disease Control's (CDC) ongoing nationwide surveillance of abortion mortality[5]; we used as a denominator the total number of abortions reported by the Alan Guttmacher Institute (AGI).[6] We applied the annual CDC distributions of age and racial characteristics of women obtaining abortions[7] to the AGI totals to estimate distributions of abortions by age and race for each year.

We obtained all data on maternal deaths and live births in the United States from the national vital statistics system of the National Center for Health Statistics.[7,8] To determine the number of deaths from childbearing, we excluded all abortion-related deaths and deaths from ectopic pregnancies from the total number of maternal deaths. We calculated the childbearing mortality rate as the number of these deaths per 100,000 live births. The effect of excluding deaths from abortion and ectopic pregnancy from maternal deaths in calculating childbearing mortality rates presents a conservative estimate of this risk.

We used two independent approaches to control for potential differences between our comparison populations of women terminating pregnancy v women continuing their pregnancies to term. We first adjusted for demographic characteristics by standardizing both the abortion and the childbearing mortality rates directly

Table 1.—Death-to-Case Rates for Legal Abortion, by Year, Age, and Race, 1972 Through 1978

Characteristic	No. of Deaths	No. of Abortions*	Rate†
Year			
1972	24	587,000	4.1
1973	25	745,000	3.4
1974	25	899,000	2.8
1975	29	1,034,000	2.8
1976	11	1,179,000	0.9
1977	17	1,317,000	1.3
1978	7	1,410,000	0.5
Age, yr			
≤19	29	2,292,000	1.3
20-24	49	2,382,000	2.1
25-29	26	1,314,000	2.0
30-34	17	669,000	2.5
≥35	17	494,000	3.4
Race			
W	65	4,975,000	1.3
B and other	73	2,196,000	3.3
Total	138	7,170,000	1.9

*Specific numbers may not add to total due to rounding.
†Deaths per 100,000 abortions.

Table 2.—Childbearing* Mortality Rates by Year, Age, and Race, 1972 Through 1978

Characteristic	No. of Deaths	No. of Live Births†	Rate‡
Year			
1972	494	3,258,000	15.2
1973	395	3,137,000	12.6
1974	383	3,160,000	12.1
1975	326	3,144,000	10.4
1976	333	3,168,000	10.5
1977	309	3,327,000	9.3
1978	268	3,333,000	8.0
Age, yr			
≤19	352	4,144,000	8.5
20-24	582	7,855,000	7.4
25-29	627	6,652,000	9.4
30-34	479	2,807,000	17.1
≥35	468	1,070,000	43.7
Race			
W	1,525	18,274,000	8.3
B and other	983	4,253,000	23.1
Total	2,508	22,527,000	11.1

*Excludes death from abortion and ectopic pregnancy.
†Specific numbers may not add to total due to rounding.
‡Deaths per 100,000 live births.

by age, race, and year. We then adjusted independently for health status by calculating risk-specific death-to-case rates for legal abortion and comparing them with published data on maternal mortality.

For our demographic comparison, we used the method of direct standardization[9] to adjust mortality rates. Age-, race-, and year-specific rates were each directly standardized by the other two variables. We used as our reference population the distributions of the white women 19 years old or younger obtaining abortion in 1972, respectively, for each of the standardized rates.

For our health status comparison, we used the criteria suggested by Nathanson[10] to determine which preexisting conditions were considered so potentially life threatening that they justified a therapeutic abortion. We determined the prevalence of these conditions among women who died from legal abortion in 1972 through 1978 by reviewing individual case reports of deaths. Detailed clinical information about 114 of the 138 abortion-related deaths was available for analysis. The prevalence rate for preexisting conditions (34%) among the 114 abortion deaths was applied to the 24 abortion deaths lacking this information.

No reliable nationwide data are available for denominators on the prevalence of preexisting conditions among women undergoing either abortion or childbearing. To estimate the prevalence of preexisting conditions among all women obtaining abortions in 1972 through 1978, we used the rates of women with preexisting conditions in hospital and nonhospital facilities that participated in our large multicenter study conducted from 1971 through 1975.[11]

Table 3.—Death-to-Case Rates for Legal Abortions and Corresponding Childbearing Mortality Rates, by Year, Age, and Race, 1972 Through 1978

	Abortion Rate*		Childbearing Rate†		Relative Risk‡
	Crude	Standardized	Crude	Standardized	
Year					
1972	4.1	4.1	15.2	18.8	4.1
1973	3.4	3.2	12.6	13.9	4.3
1974	2.8	2.8	12.1	13.9	5.3
1975	2.8	2.8	10.4	12.0	4.8
1976	0.9	0.8	10.5	11.7	14.8
1977	1.3	1.2	9.3	10.4	8.7
1978	0.5	0.4	8.0	9.1	22.8
Age, yr					
≤19	1.3	1.3	8.5	7.7	5.9
20-24	2.1	2.1	7.4	7.9	3.8
25-29	2.0	2.0	9.4	11.6	5.8
30-34	2.5	2.3	17.1	20.1	8.7
≥35	3.4	3.2	43.7	48.3	14.5
Race					
W	1.3	1.3	8.3	8.2	6.3
B and other	3.3	3.5	23.1	23.1	6.6
Overall	1.9	1.8	11.1	12.5	6.9

*Deaths per 100,000 abortions.
†Deaths per 100,000 live births.
‡Ratio of standardized childbearing rate to standardized abortion rate.

We applied these rates to the total number of abortions performed throughout the country in each type of facility during the seven-year interval. Using this approach, we estimated 1.3% of women obtaining abortions between 1972 and 1978 had preexisting conditions.

RESULTS

Secular Trends

One hundred thirty-eight women died from legal abortion from 1972 through 1978. Between 1972 and 1975, the annual number of abortion-related deaths remained stable, with a mean of 25.8±1.9 (SD of population). After 1975, the number of deaths declined to a mean of 11.7±4.1 (SD of population) (Table 1). This trend of decreased deaths in later years, combined with the progressively increasing number of abortions performed, has led to a 72% reduction in the crude death-to-case rates, from 3.2 deaths per 100,000 abortions for the years 1972 through 1975 to 0.9 deaths per 100,000 abortions for 1976

Table 4.—Serious Preexisting Medical Conditions Among Women Who Died From Legal Abortion, 1972 Through 1978

Condition	No.	%
One or more	39	34.2
Chronic heart disease	13	11.4
Obesity*	11	9.6
Hypertension†	6	5.3
Chronic respiratory tract disease	3	2.6
Chronic renal disease	3	2.6
Sickle cell disease	1	0.9
Chronic degenerative CNS disease	1	0.9
Thromboembolic disease	1	0.9
None	75	65.8
Total	114	100.0

*These women were a mean 70.6% ± 17.5% over ideal body weight for height according to Metropolitan Life tables.

†These women each had a systolic BP of 130 mm Hg or higher and a diastolic BP of 90 mm Hg or higher.

Table 5.—Estimated Death-to-Case Rates for Legal Abortion, by Preexisting Medical Conditions, 1972 Through 1978

Medical Status	No. of Deaths	No. of Abortions	Rate*
No serious preexisting medical conditions	91	7,077,000	1.3
One or more serious preexisting medical conditions	47	93,000	50.5
Total	138	7,170,000	1.9

*Deaths per 100,000 abortions.

through 1978 (Table 1). In contrast, the number of childbearing deaths has declined steadily, but at a slower pace (Table 2). This more gradual decline, coupled with the relatively constant number of births, has led to a 26% reduction in the crude childbearing death-to-case rate, from 12.6 per 100,000 live births in 1972 through 1975 to 9.3 per 100,000 live births in 1976 through 1978.

During the entire study interval, the standardized relative risk of childbearing was sevenfold higher than the standardized relative risk of abortion (Table 3). Because of the steep decline in the abortion death-to-case rate, this gap actually widened after 1975.

Demographic Factors

In general, younger women had lower death-to-case rates from either pregnancy outcome than did older women (Tables 1 and 2). The lowest rates were in the 19-years-or-younger age group of women obtaining abortions and in the group of women aged 20 to 24 years undergoing childbearing. Women aged 35 years or older had the highest rates for both groups. For all ages, childbearing had a higher risk of death than abortion. After standardization, the death-to-case rate for women 35 years or older who underwent childbearing was nearly 15-fold greater than for those who obtained abortion (Table 3).

Women of minority races were at a greater risk of death than white women for both pregnancy outcomes (Tables 1 and 2). Women of black and other races obtaining abortion had a mortality rate 2.5 times higher than white women (Table 1). Similarly, women of black and other races were 2.8 times more likely to die from childbearing than were white women (Table 2). For both racial groups, legal abortion had a lower mortality rate than childbearing (Table 3).

Preexisting Conditions

More than one in three women who died from legal abortion between 1972 and 1978 had preexisting medical conditions serious enough to qualify them for therapeutic abortions under Nathanson's criteria (Table 4). Chronic heart disease and morbid obesity were the two predominant preexisting conditions. However, hypertension, chronic respiratory tract disease, and chronic renal disease each occurred in at least three of the abortion-related deaths.

The death-to-case rate from legal abortion for women with one or more preexisting conditions was 39 times higher than that for healthy women (Table 5). Women with medical problems severe enough to justify abortion had a death-to-case rate of more than 50 per 100,000 procedures, compared with the rate of 1.3 for healthy women.

COMMENT

Deaths after legally induced abortions have fallen sharply since 1975, in contrast with the gradual decline in childbearing deaths. During our study interval, the number of legal abortions has increased progressively while that of live births has remained constant. Consequently, the difference between the risk of death from childbearing *v* the risk of death from legal abortion has widened from fivefold in 1972 through 1974' to more than tenfold in 1976 through 1978. During the most recent three-year interval, abortion has become even safer compared with childbearing.

As demonstrated in our companion article, these comparisons probably underestimate the relative safety of abortion for pregnant women. The CDC's surveillance techniques apparently identify 94% of all abortion-related deaths, while traditional vital statistics systems detect 50% to 75% of childbearing-related deaths. Abortion deaths, therefore, appear more likely than childbearing deaths to be reported completely. The abortion death-to-case rate would be correspondingly larger based on differential ascertainment.

We directly standardized the death-to-case rates to control for potentially distorting demographic factors. After this standardization, the relative risk of childbearing increased compared with abortion; the unadjusted relative risk of childbearing compared with abortion was 5.8, while the adjusted relative risk was 6.9. This difference occurs because relatively fewer women of the higher-risk ages and races are in the childbearing population. For example, 31% of women in the abortion population were of black and other races, in contrast to only 19% in the childbearing population. Adjusting the rates to the same population raises the risk for childbearing compared to abortion.

Gestational age is an important

risk factor for deaths after legal abortion.[14] However, as our previous analysis demonstrated,[4] the technique of standardization primarily affects comparisons among other categories of abortion mortality (such as age, race, and year). The crude and standardized rates were similar for gestational age and had little effect on comparisons between abortion and childbearing. To reflect more accurately the independent risk of increasing gestational age, a life-table analysis of pregnancy-related mortality rates would be preferable.[13]

For a proxy, we can use gestational age-specific death-to-case rates for women dying from abortion during our seven-year study interval.[3] At eight or fewer weeks' gestation, when more than half the procedures are performed, the risk of death from abortion was more than 20 times lower than that of childbearing. This difference declines as gestational age increases, but abortion remains the safer procedure with respect to the woman's life at gestational ages at least up through 16 weeks.

A recent analysis[2] has attempted to compare mortality risks of induced abortion and "natural pregnancy" in the first and second 20 weeks of pregnancy; it concluded that natural pregnancy was safer in both intervals.[2] However, this analytic approach fails to recognize that the woman who has successfully completed the first 20 weeks of pregnancy is still at risk of death in the next 20 weeks.[11] A woman obtaining an induced abortion, however, is obviously not subject to the risks of continuing her pregnancy to term.

Approximately one third of women who died from legal abortion between 1972 and 1978 had medical conditions serious enough to meet Nathanson's criteria for therapeutically terminating a pregnancy. However, his criteria do not include such conditions as diabetes mellitus, thrombophlebitis, and multiple sclerosis. Because these conditions were excluded, we believe our estimate of 34% of women dying from abortions having serious preexisting conditions to be somewhat conservative (Table 4).

Women with Nathanson's preexisting conditions had an abortion-related mortality rate nearly 40 times that of women without them. Confounding factors alone cannot account for this large difference, since the distribution of the women's age, race, and gestational age was relatively similar between the two groups. Women with preexisting conditions dying from abortion were slightly older than healthy women dying from abortion (mean ages, 28 and 24 years, respectively), but this difference is neither statistically nor clinically significant. The gestational age was nearly identical for the two groups, being 15.0 menstrual weeks for women with preexisting conditions and 14.6 for women without preexisting conditions. Similarly, the racial distribution for women with and without preexisting conditions was comparable, 49% and 45% being white, respectively.

If the women with preexisting conditions are removed from analysis, the death-to-case rate for legal abortion is lowered considerably. For example, the aggregate death-to-case rate from 1972 through 1978 drops from 1.9 deaths per 100,000 abortions to 1.3 deaths per 100,000 abortions. During the most recent three years, healthy women had a death-to-case rate of six deaths per 1 million abortions. The best estimate, therefore, of the current risk of dying from legal abortion for healthy women in the United States is less than one per 100,000 procedures.

No national data exist to allow calculation of the risk of childbearing for women with and without serious preexisting conditions. For purposes of comparison, however, approximately 14% of women who died from childbearing in New York State between 1970 and 1976 appear to have had one or more of Nathanson's preexisting conditions.[14] If New York State data are representative of childbearing deaths elsewhere, more women dying from abortion than those dying from childbearing had serious preexisting medical conditions. This might occur if ill women, on their physician's advice, opted to terminate their pregnancies for therapeutic reasons. Thus, contrary to some assertions,[1] pregnant women with serious preexisting health problems may be more likely to terminate their pregnancies through induced abortion than to continue their pregnancies to term. Therefore, comparative mortality data may be spuriously weighed against abortion.

CONCLUSION

Neither demographic nor health factors account for the lower risks of death from legal abortion compared with death from childbearing. Adjusting for these variables increases the apparent magnitude of the relative safety of abortion. The risk of a healthy woman's dying from elective abortion is extremely rare; in 1972 through 1978 her risk was approximately one per 100,000 abortions. Women with serious preexisting conditions have a greatly increased mortality rate regardless of the pregnancy outcome. However, even for these women, abortion is probably the safest option in terms of mortality risks.

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Document #5

Mortality From Abortion and Childbirth

Are the Statistics Biased?

Willard Cates, Jr, MD, MPH; Jack C. Smith, MS; Roger W. Rochat, MD; David A. Grimes, MD

• **Critics have challenged previous comparisons of mortality from legal abortion and childbirth for containing biases in the crude data that spuriously favor the safety of abortion. To evaluate this concern, we reviewed the sources of mortality data on which these comparisons are based and examined the completeness of abortion mortality statistics, the completeness of childbirth mortality statistics, and the accuracy of the denominators for both these events. We found the evidence to be consistent in two directions: (1) abortion deaths appear to be more completely ascertained than childbirth deaths; (2) use of different denominator estimates has relatively little impact on the comparison. From this evidence, we conclude that the crude data are biased in a direction that overestimates the abortion risks for the woman relative to the risks of childbearing.**

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MILLIONS of women in the United States confront the choice between elective abortion and childbirth each year. The safety of these two options may influence this often difficult decision. Our previous reports on abortion mortality[1,2] have compared the risks of legal abortion and childbearing for 1972 through 1975; the risk of dying from childbirth was nearly fivefold higher than the risk of dying from abortion. Our companion article (p 188) updates these previous comparisons and demonstrates that the gap actually widened in the more recent years.

See also p 188.

However, these inferences have been challenged by some critics[3-7] who contend the crude statistics are biased in three ways that spuriously favor the safety of legal abortion over childbearing. They argue that (1) social stigma is involved in abortion, which causes deaths from abortion to be misclassified more frequently—and thus undercounted—than deaths from childbearing; (2) deaths from causes unrelated to pregnancy (such as cancer, automobile accidents, or burns in pregnant women) are often classified as "maternal" deaths from childbearing—and thus overcounted; and (3) death-to-case rates artificially favor abortion because the count of legal abortions performed is too high, while the use of live births alone as a denominator for calculating the risk of childbearing is inappropriately low. They contend that if these biases are eliminated, "natural" pregnancy is safer than induced abortion.[3]

In this article we examine each of these alleged statistical biases. We first describe the sources of the data for abortion and childbearing in the United States between 1972 and 1978. We then address the three issues of bias themselves. From the available evidence, we conclude the current comparisons *are* biased—however, in the opposite direction to that alleged; they spuriously favor the safety of childbearing rather than abortion. Thus, the estimates of the relative safety of terminating a pregnancy by legal abortion compared to continuing a pregnancy to term appear conservative.

METHODS

Sources of Data

Three organizations provide primary data used in calculating the risks of dying from abortion or childbearing. The Centers for Disease Control (CDC) has conducted epidemiologic surveillance of abortion-related mortality since 1972[2] and has reported the number and characteristics of women obtaining legal abortion since 1969.[8] The National Center for Health Statistics (NCHS) publishes annual vital statistics information, including the number of deaths from abortion and childbearing and the number of live births.[9] The Alan Guttmacher Institute (AGI) has conducted an annual survey of all abortion providers since 1975 to deter-

From the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta.

Reprint requests to the Family Planning Evaluation Division, Center for Health Promotion and Education, Centers for Disease Control, Atlanta, GA 30333 (Dr Grimes).

mine the number of abortions performed in the United States." Thus, there are two sources for data on abortion deaths (CDC, NCHS), two sources for the number of abortions (CDC, AGI), and one source for data on childbearing deaths and live births (NCHS).

The CDC identifies abortion deaths through a variety of mechanisms[11]: reports from state health departments to the CDC, case histories in medical journals, reports from abortion providers and anti-abortion organizations, state maternal mortality review committees, the Food and Drug Administration, pharmaceutical companies, malpractice insurance carriers, the Commission on Professional and Hospital Activities (CPHA), and the NCHS. After learning about a death, CDC staff members contact state health department investigators or attending physicians to verify and clarify the details of the case. We classify the abortion leading to the death as legal, illegal, spontaneous, or unknown, based on definitions developed by a committee of consultants outside of the CDC.[12]

Abortion and childbearing deaths reported by NCHS represent traditional vital statistics classifications dealing with underlying cause of death.[13] These classifications are based on criteria defined by the *International Classification of Diseases-Adapted* (*ICDA*) guidelines applied to all available information listed on the death certificate. Statistics from the death certificate produced only the underlying cause of death, not contributory causes. Moreover, vital statistics data are limited to the information provided on the death certificate; hence clinical details on each death that might exist on medical records are not available through vital statistics data.

The number of abortions reported to the CDC depends primarily on the number reported to the central health agencies in the 50 states and the District of Columbia.[3] Because different states have varying approaches to collecting abortion statistics, there is no unified national reporting of abortion data.[14] The AGI directly contacts all known abortion providers annually for abortion data.[15] This active surveillance by the AGI each year generates a total number of legal abortions approximately 15% to 20% higher than that reported to the CDC.

RESULTS

Completeness of Abortion Mortality Statistics

Although it is likely that the CDC has not identified all abortion deaths in the United States since 1972, every reported death has been counted in CDC statistics. Moreover, these data appear remarkably complete. Several parallel findings support this inference: comparison of surveillance data with vital statistics data, similarities of death-to-case rates with other reports, failure of intensive record linkage studies to uncover an appreciable number of new deaths, and the inability of critics to provide any additional deaths.

Table 1.—Abortion-Related Deaths in the United States Reported to the CDC and the NCHS, 1972 Through 1978*

Year	Total Abortion Deaths by Source		Legal Abortion Deaths by Source	
	CDC†	NCHS‡	CDC†	NCHS‡
1972	90	70	24	10
1973	57	36	26	8
1974	54	27	25	6
1975	49	27	29	10
1976	27	16	11	1
1977	36	20	17	6
1978	27	16	7	2
Total	339	212	138	43

*CDC indicates Centers for Disease Control; NCHS, National Center for Health Statistics.

†Centers for Disease Control epidemiologic surveillance of abortion-related deaths, 1972 through 1978; numbers updated as reports received.

‡National Center for Health Statistics annual mortality summary.[3]

Each year since the CDC began its surveillance of abortion mortality, it has reported more deaths as abortion related than are recorded in the national vital statistics.[11] Between 1972 and 1978, the CDC counted 339 abortion-related deaths, 60% more than the 212 reported through national vital statistics (Table 1). Moreover, because surveillance techniques resolved more deaths into the specific categories of abortion (legal, illegal, spontaneous), the magnitude of the difference between the CDC and the NCHS was exaggerated for legal abortion deaths (Table 1). During the seven years from 1972 through 1978, the CDC reported 138 deaths after legal abortion compared with 43 reported in vital statistics, or over 200% more. The reason why legal abortion deaths were undercounted by the NCHS to a greater extent than total abortion deaths was due to inadequate information provided on the death certificate to allow specific classification. Most abortion deaths reported by NCHS are listed as "unspecified."[3]

Although the number of deaths reported by the CDC is higher than that of the NCHS, it may also reflect an undercount of the true number of total deaths. To determine the degree of underreporting of abortion deaths by the CDC, we used an epidemiologic approach that compares data from two sources to estimate the total number of events.[16] By matching deaths from both the NCHS and CDC files, we estimated that the CDC ascertained more than 90% of all abortion deaths.[11] Also, it appears that the surveillance system is becoming more complete the longer it is in existence.[11]

Death-to-case rates for legal abortion reported by the CDC are consistent with those reported from other investigations. To obtain complete information on all deaths after abortion performed in New York State between 1970 and 1972, physicians throughout the United States were canvassed by the CDC to determine abortion-related deaths among both residents and nonresidents[17]; the death-to-case rate during these years was 6.5 deaths per 100,000 abortions. In California between 1970 and 1972, the death-to-case rate for legal abortion was 5.1 deaths per 100,000 abortions.[18] After allowing for changes in gestational age, abortion methods, and increasing physician experience, all of which would make the procedure safer, these figures are similar to the 4.1 deaths per 100,000 abortions in the United States reported by the CDC in 1972.

A similar mortality risk has been reported from other countries.[19] National registries in England and Wales, Canada, Cuba, Czechoslovakia, Denmark, Hungary, Sweden, and Yugoslavia—countries where the quality and completeness of health data are high—have also reported death-to-case rates for abortion comparable with those in the United States. The consistency of these domestic and international studies lends support to the inference that abortion-related mortality is not being undercounted in the United States.

Investigations using extensive tracing techniques to uncover additional pregnancy-related deaths have identified few unreported abortion fatalities. In Georgia,[20] computerized

record linkage of both abortion and death certificates failed to uncover any deaths for which legally induced abortion could be causally related. In New Jersey[17] and Puerto Rico,[20] improved surveillance of maternal mortality using hospital records and death certificates identified deaths after spontaneous or illegally induced abortion, but not after legally induced abortion. Review of all deaths in CPHA hospitals during 1977 and 1978 identified two previously unreported deaths related to legal abortion (CDC, unpublished data); both situations involved procedures undertaken for therapeutic reasons. Thus, even intense searches through large data bases have led to few unreported deaths after legal abortion.

Finally, individuals and groups that allege the incompleteness of abortion mortality statistics have not, to date, been able to produce any new abortion-related deaths of which the CDC was previously unaware during the seven-year period for which the CDC has published data. In 1973, on national television, Tietze[11] offered $100 to any person who would identify an abortion death that was unreported to the CDC; this offer has been restated many times, and the stakes were raised to $150 in 1977. Yet, to date, all attempts to claim the "bounty" have produced only deaths that already had been reported to the CDC. Moreover, despite assertions[4] that an investigation of abortion clinics in Chicago uncovered 12 "unknown" abortion-related deaths, only one had not been previously identified by the CDC.

The available scientific literature strongly supports the quality and completeness of current data on abortion mortality. Surveillance techniques have apparently been successful in identifying and classifying most deaths from legal abortion.

Completeness of Childbirth Mortality Statistics

Despite assertions that childbirth-related deaths are overcounted because they include deaths to pregnant women from causes unrelated to pregnancy, the available studies of vital statistics show just the opposite. Using death certificate data and standard maternal mortality nosological classification criteria, deaths directly attributable to continuing pregnancies to term are markedly *undercounted* (Table 2). Investigations from state and international maternal mortality review committees,[19,21-23] state record linkage studies,[20,24] and a national death certificate review[25] all point in the same direction—pregnancy-related deaths from vital record sources, interpreted by the rules of the *ICDA-8*, are greatly undercounted (Table 2).

In Minnesota in the early 1950s,[21] the number of maternal deaths was increased 18% through linkage of death and live birth certificates, and an additional 20% by using case reports encouraged through the efforts of a vigorous maternal mortality review committee. In Massachusetts during the same period,[22] active contact with physicians by the maternal mortality review committee led to identification of 73% more pregnancy-related deaths than reported by state vital records.

More recent state-based investigations document similar findings. In New Jersey in 1974-1975, use of hospital maternal service records and medical examiner reports detected 45% more direct pregnancy-related deaths than death certificates alone.[17] In Georgia in 1975-1976, record linkage of deaths and births found 50% more childbirth-related deaths.[24] Finally, in Puerto Rico in 1978-1979, the discrepancy was even more striking.[20] Re-

Table 2.—Reporting of Pregnancy-Related Deaths Through Vital Statistics

Location and Years of Study	Source of Comparison Data	No. of Deaths: Official Vital Statistics	No. of Deaths: Additional Deaths	% Increase*
Minnesota, 1950-1954 (from Barno et al[21])	Record linkage	204	37	18
	Active surveillance	...	41	20
Massachusetts, 1954 (from Jewett[22])	Active surveillance	37	27	73
New Jersey, 1974-1975 (from Ziskin et al[17])	Active surveillance	11	5	45
Georgia, 1975-1976 (from Rubin et al[24])	Record linkage	24	12	50
Puerto Rico, 1978-1979 (from Speckhard[20])	Death certificate review	9	13	144
	Hospital record review	...	32	356
United States, 1974-1978 (from Smith et al[25])	Death certificate review and additional information from states	1,745	576	33
		...	171	10
England, 1970-1972 (from Arthure et al[23])	Active surveillance	355	251	71

*Percent increase indicates the number of additional deaths divided by the number of deaths identified by official vital statistics.

Table 3.—Death-to-Case Rate for Legal Abortion, by Year and Source, 1972 Through 1978

Year	Deaths*	Abortions† CDC	Abortions† AGI	Death-to-Case Rates‡ CDC	Death-to-Case Rates‡ AGI
1972	24	587,000	(587,000)§	4.1	...
1973	25	616,000	746,000	4.1	3.4
1974	25	763,000	899,000	3.2	2.8
1975	29	855,000	1,034,000	3.4	2.8
1976	11	988,000	1,179,000	1.1	0.9
1977	17	1,079,000	1,317,000	1.6	1.3
1978	7	1,168,000	1,410,000	0.6	0.5
Total	138	6,047,000	7,170,000	2.3	1.9

*Centers for Disease Control epidemiologic surveillance of abortion-related deaths, excluding deaths after ectopic pregnancy.

†CDC indicates Centers for Disease Control; AGI, Alan Guttmacher Institute. Specific numbers may not add to total due to rounding.

‡Deaths per 100,000 abortions.

§The AGI did not conduct a survey of abortion providers in 1972; thus, CDC numbers are used for estimation.

Table 4.—Death-to-Case Rate for Childbirth, by Year and Adjustment of Denominator Data, 1972 Through 1978

Year	Deaths*	Reported Live Births	Estimated Molar Pregnancies and Fetal Deaths†	Death-to-Case Rates‡	
				Live Births Only	Live Births, Molar Pregnancies, Fetal Deaths
1972	494	3,258,000	44,900	15.2	15.0
1973	396	3,137,000	42,000	12.6	12.4
1974	383	3,160,000	41,200	12.1	12.0
1975	328	3,144,000	37,800	10.4	10.2
1976	333	3,168,000	37,600	10.5	10.4
1977	309	3,327,000	37,600	9.3	9.2
1978	268	3,333,000	37,500	8.0	8.0
Total	2,508	22,527,000	278,600	11.1	11.0

*National Center for Health Statistics annual vital statistics, excludes death from abortion and ectopic pregnancies.

†Estimated from reported number of fetal deaths[9] and estimated number of molar pregnancies.[10]

‡Deaths per 100,000 live births or per 100,000 live births, molar pregnancies, and fetal deaths combined.

viewing all death certificates for pregnancy-related conditions identified nearly 1½ times more maternal deaths than reported through vital statistics. Further examination of hospital records for women dying with high-risk conditions found even more pregnancy-related deaths than by death certificate scanning. Thus, in Puerto Rico, the number of deaths reported by vital statistics was only 15% of the total. While the Puerto Rican experience may not be representative of the situation in other states, the New Jersey and Georgia data probably reflect what is happening in other areas.

National data, both in the United States and England, support the conclusions from the more circumscribed investigations. Intensive examination of death certificate and other information from 1974 through 1978 provided by 48 states and the District of Columbia identified an additional 33% more pregnancy-related deaths than reported by national vital statistics.[23] Nosological classification requirements due to *ICDA-8* accounted for 11% of the discrepancy, while additional data provided by maternal mortality review committees or state health departments added another 22%. Experience with maternal mortality in England and Wales determined that use of death certificates alone undercounts childbirth-related deaths by 71%.[22]

Thus, use of vital statistics data apparently underreports the true number of childbirth deaths, by a factor of at least one third. Unlike abortion deaths, where surveillance techniques have supplemented vital statistics information in recent years, national childbirth mortality statistics are limited by their reliance on both death certificate diagnoses alone and rigid priorities for nosological classification.

Accuracy of Denominators

Comparing the risk of dying from either legal abortion or childbearing involves not only the accuracy of the respective numerators but also, to a lesser degree, the accuracy of the denominators. For death-to-case rates from legal abortion, the denominator is the number of procedures performed. For the risks of childbearing events, the denominator is live births. Overcounting the denominator of abortions performed or undercounting the denominator of total childbearing events would spuriously underestimate the relative risk of dying from abortion compared to childbirth.

Some have alleged that because the AGI is a family planning research organization, their estimate of the total number of abortions may be too high; thus, use of their numbers as denominators to calculate death-to-case rates for legal abortion results in an artificially low rate. Some critics believe that mandatory reporting of legal abortions required by some states is more accurate than direct surveys of those providing health services. However, experience with surveillance of infectious diseases[24-26] demonstrates the opposite. In public health surveillance, though reporting of certain communicable diseases is mandatory, the number of cases reported through passive techniques is usually far less than those identified by more direct active approaches, such as that used by the AGI.

Counting the number of legal abortions is probably no different. Experience in Hawaii[27] and Tennessee[28] indicates passive reporting requirements primarily miss abortions performed in nonhospital facilities. Thus, the number of legal abortions reported to central health agencies, and eventually tabulated by the CDC, is probably less than the actual number performed. The number of abortions obtained by the AGI's survey is higher. While one cannot rule out possible overreporting to the AGI, even the AGI figure itself may be too low.[29] Regardless of whether AGI or CDC numbers are used as denominators to calculate death-to-case rates for abortion, the effect is quite small (Table 3). Between 1972 and 1978, using AGI denominators, the death-to-case rate for legal abortion was 1.9 deaths per 100,000 abortions; using CDC denominators, it was 2.3.

The use of live births alone as denominators for childbearing events has been criticized,[3] since it neglects other pregnancy-related events—such as ectopic pregnancy, molar pregnancy, or fetal death in utero—that have potentially fatal outcomes for the pregnant woman. Thus, by including such events in the numerator (all deaths from childbearing), but not in the denominator (restricted to live births), critics[3] allege that the childbearing mortality rate is artificially elevated. While this concern is hypothetically correct, in practice it makes relatively little difference. First, current investigations[3] comparing abortion and childbearing mortality have subtracted from the numerator of childbearing deaths all deaths from abortion and ectopic pregnancy; thus, there is no need to include them in the denominator. Second, compared with the number of live births, the number of fetal deaths and molar pregnancies is almost negligible (Table 4); these accounted for less than 2% of all childbearing events in recent years.[9,10,23]

Thus, claims that inaccuracies in the denominators used to calculate mortality rates for either legal abortion or childbearing artificially favor legal abortion are overstated. Even using the smaller CDC denominator for reported legal abortions (Table 3) and the larger denominator for childbearing to include stillbirths and molar pregnancies (Table 4), between 1972 and 1978 the comparative death-to-case rates are about fivefold higher for childbearing.

CONCLUSION

Examination of the data on which mortality rates for legally induced abortion and childbearing are calculated indicates the comparisons overestimate the abortion risks. In terms of dying, abortion through the 15th week of pregnancy is at least tenfold safer than childbearing. "Natural pregnancy"' is not safer for the woman than induced abortion.

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Document #6

ABORTION 1977-1979

NEED & SERVICES IN THE UNITED STATES, EACH STATE & METROPOLITAN AREA

By Stanley K. Henshaw, Ph.D., Senior Research Associate, The Alan Guttmacher Institute,
Jacqueline Darroch Forrest, Ph.D., Director of Research, The Alan Guttmacher Institute,
Ellen Sullivan, Research Associate, The Alan Guttmacher Institute
and Christopher Tietze, M.D., Senior Consultant, The Population Council

A REPORT OF THE ALAN GUTTMACHER INSTITUTE
A Corporation for Research, Policy Analysis and Public Education
360 Park Avenue South, New York, N.Y. 10010

Summary of Findings

There were 1,409,600 abortions reported in the United States in 1978, and a projected 1,540,000 occurred in 1979 (see Table A). The number of abortions increased by seven percent between 1977 and 1978 and by nine percent between 1978 and 1979.

In 1978, 2.8 percent of women of reproductive age obtained legal abortions, and 29.4 percent of women who were pregnant (excluding those who experienced miscarriages or stillbirths) chose to terminate those pregnancies by abortion. In 1979, 3.0 percent of women of reproductive age obtained legal abortions, and 30.3 percent of pregnant women obtained abortions.* Nevertheless, almost as many women carried unintended pregnancies to term as obtained abortions. Three factors appear to be contributing to the continuing increase in the abortion rate: Abortion services are gradually becoming accessible to more women, a larger proportion of women with unintended pregnancies are choosing to resolve the pregnancies by abortion, and the number of unintended pregnancies may be increasing due to shifts from the pill and IUD to less effective methods and rising sexual activity rates among unmarried women.

About one in three abortions in 1978 was obtained by a teenager; three in four, by unmarried women; and two in three, by white women. Six in 10 abortions were obtained by women who had no children, and seven in 10, by women who had had no prior abortions. The proportion of abortions accounted for by unmarried and nonwhite women declined slightly between 1977 and 1978, probably because the federal government and most states severely restricted Medicaid abortion funds. The abortion rate among women over 40 years old fell slightly in 1978, possibly reflecting greater use of contraceptive sterilization by women in this age group.

Nine percent of abortions in 1978 were performed after the first 12 weeks of pregnancy — down one percentage point from 1976 but about the same percentage as in 1977. A higher percentage of abortions were performed by instrumental evacuation (aspiration or, much less often, sharp curettage), the safest methods, in 1978 (95 percent) than in 1977 (94 percent), probably because more second-trimester abortions were performed using dilatation and evacuation in preference to saline or prostaglandin instillation. Two-thirds of all abortions performed after 12 weeks occurred in hospitals.

Abortions were performed in a total of 2,753 facilities in 1978, a net increase of only two percent over the previous year. Large facilities reporting 5,000 or more procedures in 1978 accounted for 20 percent of all abortions. There were 38 such facilities — 34 clinics and four hospitals.

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*Excluding miscarriages and stillbirths. Including an estimate of the number of miscarriages and stillbirths, approximately 25.9 percent of pregnancies were terminated by abortion in 1979.

The number of hospitals offering abortion services fell slightly between 1977 and 1978, from 1,654 to 1,626, but the number of nonhospital providers (clinics and physicians' offices) increased from 1,034 to 1,127. The number of abortions performed in the average hospital facility also decreased, from 237 to 216, while the average caseload of nonhospital facilities rose from 895 to 940. As a result of these two factors, the percentage of legal abortions performed in hospitals declined from 30 percent in 1977 to 25 percent in 1978. The decline in the proportion of abortions occurring in hospitals may be due to the lower cost of nonhospital abortions, the visibility and comprehensiveness of services available in large abortion clinics, and other factors. Abortions were performed in only 29 percent of general short-term non-Catholic hospitals — 18 percent of public hospitals and 36 percent of proprietary and voluntary hospitals.

Eight percent (a total of 113,000) of women obtaining abortions in 1978 had to cross state lines to do so, and a much larger proportion had to travel, often considerable distances, to get to the major cities in their states where most abortion facilities are located. However, geographical availability of abortion services has been gradually improving: nine percent of abortions in 1977, and even higher percentages in previous years, occurred outside the woman's state of residence. Services in the most poorly served states are expanding more rapidly than those in well-served states. The proportion of women of reproductive age living in a county with at least one abortion provider serving 400 or more women a year increased slightly from 54 percent in 1977 to 55 percent in 1978.

The need to travel long distances for abortion services is still a serious problem for many women, particularly for teenagers and low-income women, groups with relatively high rates of unintended pregnancy compared to other women. The fact that so many women travel long distances for abortion services suggests that there may also be others who would choose to have abortions but are unable to obtain them. In order to evaluate the availability of abortion services in specific geographic areas, an estimate has been made of the "need" for abortion services, that is, the number of women who would obtain abortions to terminate unwanted pregnancies if such services were readily available and accessible to them. The estimate of the number of women in need of abortion services is based on the actual behavior of residents of states with relatively good availability and accessibility of abortion services in 1978 — California, Connecticut, Hawaii, Nevada, and New York. The need estimate serves as a standard against which to measure the adequacy of abortion services in the United States. Thirty-four percent of women estimated to be in need of abortion services were unable to obtain them in 1978, and 29 percent could not get them in 1979.

Many women have been unable to obtain abortion services, in part, because of continued inaccessibility of abortion facilities: 77 percent of U.S. counties and 49 Standard Metropolitan Statistical Areas (SMSAs) had no facility in which legal abortions were performed in 1978. In states where the majority of women lived in counties without abortion facilities, a larger proportion of the women needing abortion services

went unserved than in states with more adequate services. Only five percent of abortions were performed in nonmetropolitan areas, where 26 percent of the women needing abortion services lived.

In addition, federal funds to subsidize abortions for indigent women have virtually been withdrawn as a result of the Hyde Amendment. Most states have followed suit, refusing state Medicaid funds for abortions, although a small number of large states continue to fund abortions for Medicaid recipients with state funds. Studies indicate that restrictions on Medicaid funding of abortions in 1978 probably compelled 18,000-30,000 women to have unintended births — births they would otherwise have averted by abortion.

I. Background

A majority of all pregnancies experienced by women in the United States are unintended — either not wanted until a later date or not wanted ever. It is estimated that of the 5,610,000 pregnancies in 1978, 3,095,000, or 55 percent, were unintended (see Table I-1). One out of every 16 women aged 15 to 44 experienced an unintended pregnancy in that year.

In spite of efforts to increase the availability of contraceptive services, the number and rate of unintended pregnancies appear to have increased in recent years.* A number of reasons have been suggested to account for the high and rising level of unintended pregnancy. First, a high proportion of unmarried teenagers, and presumably also of older unmarried women, have become sexually active in recent years. 1/ Unmarried women who are sexually active are unlikely to desire pregnancy but may be less effective contraceptors due to inexperience, intermittent patterns of sexual activity, attitudinal factors, and other reasons. Second, even the best reversible contraceptive methods have failure rates in actual use that result in many accidental pregnancies. According to data from the 1973 and 1976 National Surveys of Family Growth, 2.5 percent of married women using oral contraceptives experience accidental pregnancies during the first year of use, as do 4.8 percent of those using IUD's, 9.6 percent of those using condoms, and 14.4 percent of those using diaphragms. 2/ This means that a woman using the best reversible contraceptive methods nevertheless has a fair probability of becoming pregnant accidentally sometime during her reproductive years. Third, the perception of health risks associated with the pill and IUD has resulted in a shift to use of less effective reversible methods.** This shift, however, has been at least partly offset by an increase in use of sterilization 3/ and an overall increase in contraceptive practice. 4/

In 1978 about half the women faced with an unintended pregnancy terminated the pregnancy by abortion and half carried the pregnancy to term (see Table I-1, Panel 4). As a consequence, between mid-1978 and mid-1979, about 1,287,000 births resulted from unintended pregnancies (see Table I-1, Panel 1). This amounts to 38 percent of all births during this period. There is evidence (summarized in Section IV below) that many of the women who carried unintended pregnancies to term would have chosen to terminate these pregnancies by abortion if abortion services had been readily available to them.

The abortion rate is determined by the rate of unintended pregnancy and by the proportion of unintentionally pregnant women who have access to abortion services and utilize these services to resolve the pregnancy.

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*Calculated from the numbers of abortions and special tabulations of the 1973 and 1976 National Surveys of Family Growth.

**Evidence for such a shift may be seen in the 1973 and 1976 National Surveys of Family Growth and in the Johns Hopkins Surveys of Young Women. See references 1 and 3.

IV. Need for Abortion Services

The unavailability of abortion services locally presents a serious problem for many women who might wish to resolve an unintended pregnancy by abortion. A long distance to the nearest provider may make it difficult for a woman to obtain information about the existence of the provider, the services offered, and their costs. Counseling by the trained staff of an abortion facility is unavailable until the woman has already invested time and money in travel. Distance adds significantly to the cost of an abortion due to travel, food and lodging expenses. It increases the time a woman must take from other activities to obtain the abortion, which may involve additional child-care expenses and, for a working woman, may result in lost income and other job problems. Confidentiality is jeopardized by the need to be away from home for a longer period of time -- possibly one or two nights rather than a few hours. The problems posed by distance are particularly severe for teenagers and low-income women, groups with relatively high need for abortion services.

For the women who succeed in overcoming these problems in obtaining abortions, distance has additional disadvantages. From a medical viewpoint, a long distance is undesirable because the time spent making travel arrangements may delay the abortion to a later, less safe period of gestation. There is increased likelihood that a woman will be unable to return for a followup examination, and the abortion facility will be unavailable to treat complications that may occur after the patient returns home. Extensive travel immediately after an abortion procedure may not be helpful to recuperation.

While some women are able to overcome the barriers of distance to obtain abortion services, others carry unintended pregnancies to term when abortion services are unavailable locally. A study of abortion rates in Georgia counties has shown that abortion rates rise sharply when services become available in previously unserved areas.7/ This study also found that abortion rates in rural counties were as affected by increased availability as were the rates in urban areas. These results suggest that the low abortion rates observed in many rural areas are due, at least in part, to lack of abortion services, not just to differing values and preferences of rural people.

In order to assess the adequacy of abortion services, it is important to measure the extent to which the services available in specific geographic areas are able to meet the needs of local residents. For this purpose, it is helpful to estimate the number of women in each area who might be expected to want and seek abortions in a given year, that is, the number of women who have unintended pregnancies and would choose to terminate their pregnancies by abortion if abortion services were readily available.

It is possible to estimate the expected need, or potential demand, for abortion services for a given area by using as a standard the experience of areas with good abortion service availability. Since abortion

utilization varies greatly by age and race, it is important to take into account the age and race distribution of the population of a geographic area when estimating its need for abortion services.

In previous reports, various standards have been used to estimate the need for abortion services based on data available at the time. 8/ For 1973 through 1975 two estimates were made, one based on the abortion experience of California in 1973 and one based on that of New York City residents in 1971. Since that time, better information on use of abortion services has become available in other states, and more states have come to have relatively adequate abortion services. Need estimates for 1976 and 1977 were based on the six states with the highest resident abortion rates in 1976 — Washington, Massachusetts, New Jersey, Maryland, New York and California. The age-specific and race-specific abortion rates calculated on an aggregate basis for these states for 1976 were applied to estimates of the U.S. female population, to yield 1,791,000 women in need of abortion services in 1976. The expected abortion rate if all need were met was 37.2 abortions per 1,000 women of reproductive age. This estimate was regarded as conservative since access to abortion services was far from universal even in the criterion states.

Since 1976, abortion services have become more available and abortion rates have continued to rise even in relatively well-served states. By 1978 five states had relatively adequate abortion services; in these states at least 80 percent of women aged 15-44 lived in counties with one or more facilities providing 400 or more abortions a year. These five states, California, Connecticut, Hawaii, Nevada and New York, were taken as the criterion states for assessing the adequacy of abortion services in 1978. The two most populous of the states, California and New York, were also among the states used as a standard in estimating abortion services need in 1976.

The aggregate resident abortion rate of the five states was 42.9 abortions per 1,000 women of reproductive age in 1978. It is assumed that if abortion services were as readily available throughout the country as they were to women living in those states in 1978, women throughout the country would also have abortions at about the rate of 42.9 per 1,000. On this assumption, the number of women in need of abortion services in 1978 was 2,146,100.* Due to population growth, the number in 1979 was slightly greater at 2,181,000. Since the number of reported abortions in 1978 was 1,409,600, there were an estimated 736,500

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* Since the age and race distributions of women obtaining abortions were unavailable for most of the criterion states, and since the age/race distribution of the female population in these states was similar to that for the country as a whole, the aggregate abortion rate in the criterion states (42.9) was applied directly to the U.S. population of women 15-44 to arrive at the number of women estimated to have needed abortion services in 1978.

women who did not obtain abortions, but would have done so if abortion services had been readily available. "Readily available" in this context refers to the absence of economic, legal, and other barriers to service as well as to geographic accessibility.

The estimate of need does not assume that all women with unintended pregnancies would choose to have abortions if services were available. Some women who had unintended pregnancies would come to want to have the baby, and others simply would not have an abortion even to terminate an unwanted pregnancy for personal, moral or religious reasons. As was shown earlier, there were 2,697,000 unintended pregnancies that terminated in either live births or abortions in 1978. If all the women estimated to have been in need of abortion services had in fact had abortions, there would still have been approximately 612,000 births resulting from unplanned pregnancies.

In estimating the need for abortion services for states and other geographic areas, the age and race composition of the population of each area has been taken into account. The age- and race-specific expected abortion rates, based on the age-race distribution of women obtaining abortions for the country as a whole, are as follows*:

	Expected abortions per 1,000 women	
Age	White	Nonwhite
15-19	55.2	109.1
20-24	59.9	149.8
25-44	18.9	63.4

When these rates are applied to the population of a particular state, the resulting overall expected abortion rate (the rate expected if all women estimated to need abortion services were able to obtain them) may be higher or lower than the overall rate of 42.9 for the country as a whole. For example, the expected rate for Vermont is 35.5 abortions per 1,000 women of reproductive age because of its low nonwhite population, while that for Mississippi is 60 percent higher at 57.4 due to the large proportion of nonwhites in that state. Similarly, an area with a high proportion of women in the younger age groups (under 25) would have a higher expected abortion rate than one whose women were older on the average.

* To calculate the age-race specific rates, the 2,146,100 women in need of abortion services were distributed to age-race groups in the same proportions as all 1978 abortions, as estimated by AGI based on CDC data. Rates were then calculated by dividing the estimated number of women in need in each age-race group by the U.S. female population in that group.

The need estimates do not indicate exactly the number of women in a given area in need of abortion services in a given year. They would be more accurate if additional variables such as income level and marital status could be taken into account. The population estimates on which they are based are subject to a degree of error, especially in areas with small populations, due to the length of time since the 1970 census. Nevertheless, the need figures are reasonable estimates of the general levels of abortion services required, based on available data on women's behavior under conditions of relatively wide service availability.

V. Availability of Abortion Services

How much of the need for services was met?

Estimates of the need for abortion services indicate the potential demand for abortions, i.e., the number of women who experience unintended pregnancies and who would use abortion services if they were available. The unmet need for abortion services is the difference between the estimated need and the number of abortions which occur. The purpose of the need estimates is to identify those areas where services are most lacking and to assist planners to develop priorities for future abortion service development.

In 1978, an estimated 2,146,000 women were in need of abortion services. The 1,410,000 abortions which took place in 1978 was 66 percent of this level. Nationally, 736,000 women were unable to obtain the abortion services they needed. Among the women who did obtain abortions, 113,000 traveled outside their home states to do so, and many other women traveled within their state but outside their home communities for abortion services (see Table V-1).

Overall, the percentage of women in need of abortion services who were able to obtain them varied greatly both within and between states. In some states, namely California, Nevada, New York, Washington and the District of Columbia, a combination of in-state and out-of-state services provided for almost all the residents in need of abortion services. In other states, including Alabama, Arkansas, Idaho, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, West Virginia and Wisconsin, less than half of the need for abortion services was met. In four states, Illinois, Ohio, Pennsylvania, and Texas, more than 40,000 women in need of services were unable to obtain abortions.

In two census divisions of the country, Mid-Atlantic and Pacific, over 80 percent of the residents estimated to be in need of abortion services obtained abortions. In the West North Central and East South Central divisions, however, less than half of the services need was met. The East North Central division had the largest number of women, about 170,000, who were unable to obtain needed abortion services.

Estimates of the proportion of the abortion services need met and unmet at the substate level (SMSA* and county) have also been made. These estimates, however, have to be interpreted carefully because abortions are reported by where they occur and need is estimated on the basis of where women reside. Therefore, the provision of services may look unrealistically favorable in those areas to which women travel for abortions and may look overly unfavorable in those areas from which they travel. Table 1 in the Detailed Tables section compares the number of abortions reported to have occurred in each SMSA and in the remaining nonmetropolitan areas of each state in 1978 with the estimated number of women in need of abortion services.

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* Standard Metropolitan Statistical Area.

Table V-1. Estimated number of women in need of abortion services, number of abortions, unmet need and percentage of need met to residents in their home state and other states, and to residents in their home state, 1978

Census division and state	No. of women in need of abortion services	Abortions to residents (in state and out of state)	Unmet need	% of need met (in state and out of state)	No. of abortions to residents in their home state	Need not met within state	% of need met in woman's home state
U.S. total	2,146,090	1,409,600	736,490	66	1,296,640	849,450	60
New England	104,790	79,350	25,440	76	72,950	31,840	70
Mid-Atlantic	352,160	294,940	57,220	84	278,120	74,040	79
E. North Central	391,160	221,430	169,710	57	203,470	187,690	52
W. North Central	146,180	61,610	84,570	42	48,360	97,820	33
South Atlantic	393,550	235,110	158,440	60	201,830	191,720	51
E. South Central	149,380	56,920	92,460	38	46,220	103,160	31
W. South Central	226,550	113,190	113,360	50	109,160	117,390	48
Mountain	98,190	56,960	41,230	58	50,900	47,290	52
Pacific	284,130	290,070	†	†	285,630	†	†
Alabama	43,070	16,310	26,360	38	13,770	29,300	32
Alaska	3,210	3,110	2,100	60	2,580	2,630	50
Arizona	24,100	13,650	10,450	57	13,080	11,020	54
Arkansas	22,760	6,930	15,830	30	4,930	17,830	22
California	213,820	232,700	†	†	231,470	†	†
Colorado	25,940	18,480	7,460	71	18,020	7,920	69
Connecticut	26,590	20,040	6,550	75	17,660	8,930	66
Delaware	6,330	4,270	2,060	67	3,170	3,160	50
D.C.	13,760	14,680	†	†	14,280	†	†
Florida	87,030	56,460	30,570	65	56,010	31,020	64
Georgia	61,880	34,950	26,930	56	31,370	30,310	51
Hawaii*	14,630	6,870	7,760	47	6,850	7,780	47
Idaho	7,400	2,650	4,750	36	1,680	5,720	23
Illinois	112,740	70,230	42,490	62	65,220	47,320	58
Indiana	47,700	24,650	23,050	52	15,030	32,670	32
Iowa	22,790	8,920	13,870	39	6,220	16,570	27
Kansas	19,790	8,630	11,160	44	7,750	12,040	39
Kentucky	31,380	12,910	18,670	41	10,350	21,230	33
Louisiana	48,680	12,970	35,710	27	12,280	36,400	25
Maine	8,850	5,420	3,430	61	5,040	3,810	57
Maryland	48,890	38,230	10,660	78	24,800	24,090	51
Massachusetts	51,270	40,760	10,510	80	39,840	11,430	78
Michigan	91,170	53,870	37,300	59	52,700	38,470	58
Minnesota	33,010	15,300	17,710	46	14,820	18,190	45
Mississippi	31,270	8,080	23,190	26	3,710	27,560	12
Missouri	44,730	20,180	24,550	45	13,190	31,540	29
Montana	7,050	3,720	3,330	53	2,980	4,070	42
Nebraska	13,580	5,000	8,580	37	4,630	8,950	34
Nevada	6,130	6,180	†	†	5,210	920	85
New Hampshire	6,650	4,520	2,130	68	3,650	3,000	55
New Jersey	70,350	57,640	12,910	82	46,630	23,900	66
New Mexico	12,350	6,590	5,760	53	5,910	6,440	48
New York	176,520	174,650	1,870	99	172,830	3,690	98
North Carolina	64,720	30,310	34,210	47	28,580	36,140	44
North Dakota	6,010	1,410	4,600	23	890	5,120	15
Ohio	100,070	56,170	43,900	56	54,170	45,900	54
Oklahoma	25,920	10,300	15,620	41	9,920	16,000	38
Oregon	19,800	13,950	3,850	81	13,860	5,940	70
Pennsylvania	105,090	62,630	42,440	60	58,640	46,450	56
Rhode Island	7,360	5,350	2,210	71	4,200	3,360	56
South Carolina	37,990	15,340	22,630	40	12,700	25,290	33
South Dakota	6,270	2,170	4,100	35	860	5,410	14
Tennessee	43,460	19,420	24,040	45	18,390	25,070	42
Texas	129,190	82,790	46,400	64	82,030	47,160	63
Utah	11,470	3,650	7,820	32	2,970	8,500	26
Vermont	3,870	3,260	610	84	2,560	1,310	66
Virginia	57,770	34,500	23,270	60	28,320	29,450	49
Washington	30,670	31,440	†	†	30,370	†	†
West Virginia	15,180	6,170	9,010	41	2,400	12,780	16
Wisconsin	39,480	16,310	22,970	42	16,350	23,130	41
Wyoming	3,750	2,040	1,710	54	1,050	2,700	28

† The number of abortions was equal to or exceeded the estimated number of women in need.

* The need for abortion services in Hawaii may be overestimated due to the classification of women of Hawaiian and Oriental descent as nonwhite.

Note: Numbers may not add to totals because of rounding.

Abortion services are much more readily available in metropolitan areas than in nonmetropolitan counties, and among the metropolitan areas, those with the largest populations are most likely to provide abortion services that equal or exceed the estimated number of residents expected to need these services (see Table V-2). For example, eight of the 13 SMSAs with more than 500,000 women aged 15-44 report abortions at least equal to the need. In these SMSAs collectively, 13,060 more abortions took place than the estimated number of resident women in need. These figures illustrate the fact that many women from surrounding areas look to the large urban areas for their abortion services. By way of contrast, only 10 percent of the smallest SMSAs — those with fewer than 100,000 women aged 15-44 -- reported a number of abortions equal to the estimated need for abortion services. In the smallest SMSAs collectively, 48 percent of the abortion services need was met.

Table V-3 lists the 49 SMSAs with no identified abortion provider and the four SMSAs in which providers were identified but served less than one percent of the estimated number of women in need. These 53 areas contained between 660 (Sherman, Texas) and 4,360 (Shreveport, Louisiana) women in need of abortion services, and in total they contained 84,240 women whose need for abortion services is not met. Some of the residents of these areas needing abortion services may have obtained them elsewhere, but many did not. New abortion facilities would undoubtedly find that services in these metropolitan areas would be utilized. In addition, there were 48 other SMSAs where at least one percent of the need was met but where 2,000 or more women remained unserved. Texas had the most unserved SMSAs with 10 (see Table V-3). Louisiana and Ohio each had five unserved SMSAs.

Abortion services were also in short supply in the nonmetropolitan areas of the country, where the number of reported abortions amounted to only 12 percent of the estimated need. By way of contrast, the number of abortions in metropolitan counties nationally equalled 84 percent of the estimated number of metropolitan women needing abortion services. Nationally there were an estimated 550,000 nonmetropolitan women who needed abortion services in 1978, whereas only 64,000 abortions took place in nonmetropolitan areas. Many of the nonmetropolitan women undoubtedly obtained abortions in metropolitan areas, with considerable difficulty for some, while others carried their unintended pregnancies to term.

An important measure of accessibility of abortion services is the presence of an abortion provider within a woman's county of residence. Even in rural areas, most women look to the population centers of their counties for health services. A provider serving a large number of abortion patients is likely to be a more accessible resource than a small provider, who may not be well known and may limit services to established patients.

As may be seen from Table V-4, 77 percent of U.S. counties had no identified abortion facility providing even one abortion during the year, and 84 percent had no facility reporting as many as 30 a year, or two a

month. An estimated 27 percent of women in need of abortion services lived in counties with no provider, and an additional five percent lived in counties where the largest provider reported fewer than 30 abortions during the year. The inadequacy of abortion services was especially evident in nonmetropolitan counties, 92 percent of which had no abortion provider serving even 30 women annually.

Most of the unserved nonmetropolitan counties have relatively small (under 400) numbers of women in need of abortion services. Services could be made available in such counties if a local physician chose to perform abortion procedures. In most cases the procedures would take place in a local hospital; most physicians with a small abortion caseload would not have the necessary equipment available in their offices. It is not clear to what extent the barrier to providing such services is the reluctance of physicians to perform abortions or restrictions imposed by hospitals on the use of their facilities for this purpose.

However, the many underserved counties where there is a potential demand for 400 or more abortion procedures could support small but adequately equipped abortion clinics. Such clinics serve a minimum of eight patients a week. The abortions are performed either by a local physician or one who comes from another area for the necessary number of hours a week.

As Table V-5 shows, there are 362 counties with no abortion provider reporting as many as 30 procedures a year and with an estimated 400 or more women in need of abortion services. There are 292,820 women in need of abortion services in these counties. Four states have more than 25 counties that singly or in groups could support an abortion clinic as described above: Louisiana, Ohio, South Carolina and Texas. Each of these states has more than 20,000 women in need of abortion services in these underserved counties. In South Carolina, 59 percent of women estimated to be in need of abortion services live in such counties; in Louisiana and Mississippi 40 percent of the women in need live in such counties. All but 10 states had at least one underserved county that could potentially support an abortion clinic.

The importance of accessible abortion services is illustrated in Table V-6, which compares the 10 states with the greatest availability of abortion services with the 10 states with least available services. (Service availability was measured by the proportion of women in need of abortion services who lived in counties with a facility providing at least 30 abortions during 1978.) In the states with the most available services, an average of 81 percent of the residents needing abortion services obtained them, either inside or outside the state, while in the 10 least well served states, only 34 percent of the need was met. Thus it is evident that if women are to receive the abortion services they want and need, it is important to have services available within their home counties or within a reasonable travel distance of their homes.

Trends in Availability

While abortion services increased rapidly in the first years after the Supreme Court decisions legalizing abortion in 1973, the rate of increase has been slow in recent years. As was explained earlier, the proportion of abortions occurring outside the woman's home state declined slightly, from 10 percent in 1976 to eight percent in 1978. Similarly, the abortion rates of the states whose rates are lowest are increasing somewhat more rapidly than those of the states with higher rates.

Two other measures of abortion service availability, the proportion of counties with services and the proportion of women living in counties with services, are shown in Table V-7. As may be seen from this table, there has been no change recently in the proportion of counties without a facility providing even one abortion per year or in the proportion of all women 15-44 living in such counties. In all three years, 1976, 1977 and 1978, 77 percent of counties had no abortion provider and 28 percent of women of reproductive age lived in counties with no abortion services. A slight improvement is evident, however, in the proportion of women living in counties with a large provider, that is, a provider serving 400 or more abortion patients during the year. This proportion rose from 51 percent in 1976 to 54 percent in 1977 and 55 percent in 1978. Compared to smaller providers, facilities performing 400 or more abortions usually represent more available services because larger providers are more visible and less likely to impose restrictions on services. Thus, there appears to be a continuing slight increase in the geographical availability of abortion services. This increase is probably due to growth in provider caseloads rather than relocation of providers in more populous counties.

Potential Hospital Providers

While there is enough potential demand for abortion services to support a free-standing abortion clinic in only 14 percent of the underserved counties,* many of these counties have hospitals in which outpatient abortion services could be established at reasonable cost. Both private (voluntary and proprietary) and public hospitals have enormous potential for improving the availability of services.

As may be seen in Table V-8, in 1978 abortions were provided in 29 percent of all short-term general non-Catholic hospitals. In only 20 percent of hospitals were as many as 30 abortions performed during the year (not shown). In the country as a whole there were 1,728 public and 2,185 private hospitals in which no abortion services at all were provided in 1978. Most of the public nonprovider hospitals and about half of the private ones were in nonmetropolitan areas, where abortion services are often unavailable from any other source. Two-thirds of the nonprovider hospitals were located in counties with no identified abortion facility.

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* A caseload of 400 abortion patients a year is estimated to be the minimum size needed to support a free-standing clinic.

All of the 53 SMSAs with no abortion services (or with facilities meeting less than one percent of the need) had at least one hospital that could have provided such services; 29 had one or more public hospitals and 50 had one or more private hospitals. Of the other 78 SMSAs with less than 50 percent of need met, 42 had nonprovider public hospitals and 58 had nonprovider private hospitals that could have offered abortion services. Table 4 in the Detailed Tables section shows for each SMSA the number of public and private general short-term non-Catholic hospitals in which no abortions were performed.

Private hospitals are somewhat more likely than public hospitals to offer abortion services: 36 percent of the private, but only 18 percent of the public hospitals reported that at least one abortion was performed there in 1978. This pattern holds for both metropolitan and nonmetropolitan areas.

Document #7

Abortion Services in the United States, 1979 and 1980

By Stanley K. Henshaw, Jacqueline Darroch Forrest, Ellen Sullivan and Christopher Tietze

Summary

• There were 1.55 million legal abortions in the United States in 1980. About three percent of the 53 million women of reproductive age obtained an abortion, and one-fourth of pregnancies—a little less than half of all that were unintended—were terminated by abortion.

• While the abortion rate is increasing somewhat, the increases have become progressively smaller over the years. The rate increased by two percent between 1979 and 1980, compared with an increase of four percent between 1978 and 1979, and with larger increases in previous years. If these trends continue, the abortion rate may be expected to stabilize at 1980 levels or to rise only slightly. Several factors help account for the continuing increase in the abortion rate.

• The most important factor influencing the increase since 1975 appears to be a rise in the rate of unintended conceptions. This increase is attributable mainly to a sizable shift from use of the most effective reversible methods of contraception, the pill and the IUD, largely as a result of reports of serious although rare health consequences associated with their use.

• Geographic availability of abortion services increased slightly between 1978 and 1980, despite the heightened public controversy over abortion (which might have been expected to have a chilling effect upon potential providers). Nonetheless, abortion services are still not readily available to all women. Seventy-eight percent of all U.S. counties had no identified abortion service provider in 1980, and 28 percent of women of reproductive age lived in these counties.

• Fifty-nine of the nation's 305 standard metropolitan statistical areas (SMSAs), which contain cities of substantial size, had no facility providing abortions, and an additional 25 SMSAs reported fewer than 50 abortions in 1980.

• Three-fourths of all abortions in 1980 took place in the 459 clinics and hospitals that provided 1,000 or more abortions each, although abortions were reported in 2,758 different facilities.

• Almost 80 percent of all abortions were performed in nonhospital facilities in 1980, compared with fewer than 30 percent in 1973. The proportion performed in hospitals dropped from a high of 52 percent in 1973 to just 22 percent in 1980. Among the reasons for this change in type of provider is that improvements in and simplifications of the technology by means of which abortions can be performed safely have made services in freestanding facilities an increasingly practical and suitable option, far less costly than hospital-based services.

• About one in 10 obstetrician-gynecologists in private practice performed abortions in their offices 1980.

Factors in addition to limitations on geographic availability that restrict women's access to abortion services are

• the lack of Medicaid funding for most abortions in all but 14 states and the District of Columbia, affecting the poorest women;

• parental notification and consent requirements imposed by 19 percent of abortion clinics and by law in seven states (although the constitutionality of such legislative requirements is being challenged in the courts);

• the fact that 30 percent of abortion providers perform abortions only at 10 or fewer weeks' gestation and that only 21 percent perform abortions after 14 weeks, as measured from the last menstrual period;

• the absence of outpatient abortion services

About one-fourth of all pregnancies, just under one-half of all that were unintended, were terminated by abortion in 1980. Increases in the abortion rate, which was 30.0 per 1,000 live births in 1980, are slowing; if the trend continues, the abortion rate should stabilize this year.

Abortion in a freestanding clinic. About 8 in 10 terminations occurred in such facilities in 1980.

Stanley K. Henshaw is Senior Research Associate, Jacqueline Darroch Forrest is Director of Research and Ellen Sullivan is Research Associate with The Alan Guttmacher Institute. Christopher Tietze, a member of the Institute's Science Advisory Panel, is Senior Consultant with The Population Council and directs its abortion research activities. The survey on which this article is based was supported in part by grants from The George Gund Foundation, The Huber Foundation and The David and Lucile Packard Foundation. Details of the methodology and detailed tables may be found in S. Henshaw, J. D. Forrest, E. Sullivan and C. Tietze, *Abortion 1979–1980: Need & Services in the United States, Each State & Metropolitan Area*, The Alan Guttmacher Institute, New York, 1982 (forthcoming).

Table 1. Number of reported abortions and number of facilities, by metropolitan status; rate of abortions per 1,000 women aged 15–44; and ratio of abortions per 1,000 abortions plus live births; United States, 1973–1980

Measure and metropolitan status	1973	1974	1975	1976	1977	1978	1979	1980* (Proj. pop.)	1980† (Census)
(1) No. of abortions (000s)									
Total	744.6	898.6	1,034.2	1,179.3	1,316.7	1,409.6	1,497.7	1,553.9	1,553.9
Metro	720.2	860.7	985.7	1,123.3	1,258.0	1,345.2	1,430.9	1,483.9	1,507.7
Nonmetro	24.4	37.9	48.5	56.0	58.7	64.4	66.8	70.0	46.2
(2) No. of facilities									
Total	1,627	2,028	2,398	2,567	2,688	2,753	2,734	2,758	2,758
Metro	1,302	1,615	1,903	2,036	2,139	2,198	2,213	2,244	2,318
Nonmetro	325	413	495	531	549	555	521	514	440
(3) Abortion rate	16.6	19.6	22.1	24.5	26.9	28.2	29.3	30.0	29.4
(4) Abortions per 1,000 abortions plus live births‡	193	220	249	265	286	294	297	300	300

*Metropolitan status and population estimates comparable to those used for 1979 calculations. See † on page 7.

†Metropolitan status and population estimates based on 1980 census. The April 1, 1980, census count was used since projections were not available for July 1, 1980, national and state populations by sex and age. It is estimated that the abortion rate based on the July 1 population would be 29.3.

‡For each year, births occurring during the 12-month period starting in July of that year (to match time of conception of pregnancies ending in births with that of pregnancies ending in abortions).

Sources: 1973–1978—see reference 2; 1979–1980 abortion and provider data—AGI abortion survey; population data—U.S. Bureau of the Census, "Estimates of the Population of the United States, by Age, Race, and Sex: 1976–1979," *Current Population Reports*, Series P–25, No. 870, 1980, Table 2; ——, "Projections of the Population of the United States: 1977 to 2050," *Current Population Reports*, Series P–25, No. 704, 1977, Table 8; and ——, "Age; Sex, Race, and Spanish Origin of the Population by Regions, Divisions, and States: 1980," *Supplementary Reports*, PC80–S1–1, 1981; birth data—National Center for Health Statistics, DHHS, "Births, Marriages, Divorces, and Deaths for June 1981," *Monthly Vital Statistics Report*, Vol. 30, No. 6, 1981.

in 45 percent of the hospitals that provide abortions; and

- the practice of 74 percent of hospitals reporting abortions not to accept abortion patients directly but to require that they be referred by an attending physician.

Introduction and Methodology

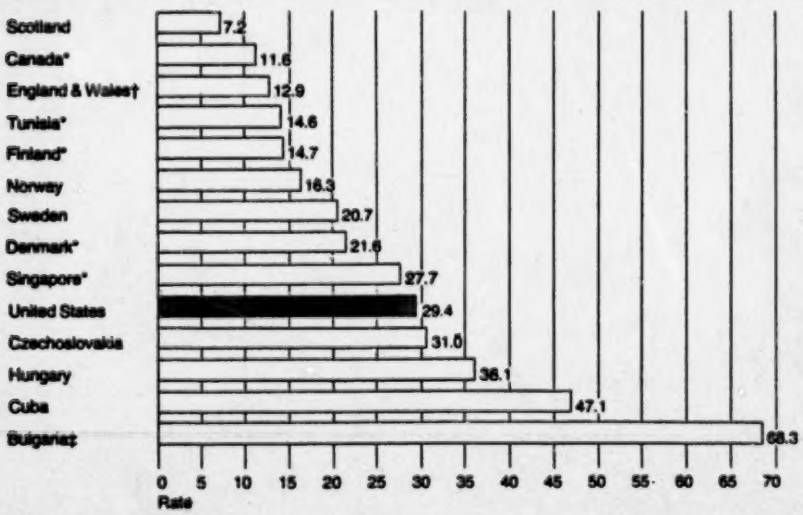
Since the 1973 Supreme Court rulings legalizing abortion in the United States, The Alan Guttmacher Institute (AGI) has monitored the availability and accessibility of abortion services throughout the country through national surveys of all known providers of abortion services—public and private hospitals, freestanding clinics and private physicians. The data thus obtained provide the only national information on the number of abortion service providers and the numbers of abortions by geographic area and by type of facility. This article describes some of the results of the AGI's seventh abortion survey, fielded in the spring and summer of 1981 and covering two years, 1979 and 1980. In this article, we will concentrate on the availability and accessibility of abortion services according to such factors as geographic concentration of services, types of facilities, Medicaid funding, parental notification and consent restrictions, acceptance of self-referred patients and limits on the gestational age at which abortions are performed.

In the 1981 survey, providers were asked to report the number of abortions performed in 1979 and 1980, and to provide gestational data and information about the delivery of services. Questionnaires were sent to facilities that had reported abortions in either 1977 or 1978 as well as to other facilities thought to have provided abortions in 1979 or 1980. New providers were identified through newspaper articles from a national clipping service and through queries to persons knowledgeable about local abortion services, such as state coordinators of the National Abortion Rights Action League and Planned Parenthood affiliates.

Two follow-up mailings were sent to facilities that did not respond to the original one. If no response was received, state health department data were used where available; if they were not available, attempts were made to elicit the information through telephone calls. In a few instances, when these efforts were unsuccessful, estimates were obtained from knowledgeable persons in the community. By means of these procedures, information was obtained for 94 percent of the potential respondents. The most extensive follow-up efforts were concentrated on the larger providers; nonrespondents are believed to have provided few abortions in the study years.*

The number of abortions reported to the AGI is typically higher than the number reported to the Centers for Disease Control (CDC),[1] the other source of national data on abortion. The reason is that the AGI surveys providers directly, while the CDC data for most states are based on summary information reported by state health departments, which may not receive information from all

Figure 1. Rates of legal abortion per 1,000 women aged 15–44, various countries, 1980



*1979. †Residents only. ‡1978.

Sources: C. Tietze, *Induced Abortion: A World Review*, The Population Council, New York, 1981; and data collected by C. Tietze from various sources.

*For a more detailed explanation of the survey methodology, see reference 2 and citation in biographical footnote on page 3.

providers. Discrepancies between the resulting national estimates are due to differences in the methods of data collection.*

Although the AGI surveys undoubtedly include almost all sizable abortion providers, there are probably some smaller providers that have not been identified. Supplementary sample surveys of obstetrician-gynecologists and of hospitals have been conducted to estimate the degree of error.[2] Data from both these surveys suggest that the actual number of abortions performed may in fact be three to six percent higher than the number reported to the AGI. The numbers and analyses presented here are based on the reported number of abortions; data are not adjusted for the possible undercount.

Findings

As panel 1 of Table 1 shows, there were 1,497,700 legal abortions in 1979 and 1,553,900 in 1980. About three percent of the 53 million women aged 15–44 (29.4 per 1,000, as seen in panel 3†) obtained legal abortions in 1980. As in previous years, the vast majority of abortions (96 percent) were concentrated in metropolitan areas. The overall number of providers (panel 2) and the number in metropolitan areas rose slightly in 1980, but the number in nonmetropolitan areas declined somewhat. The ratio was 300 abortions per 1,000 pregnancies ending in live births or abortions (panel 4). When miscarriages and stillbirths are taken into account, the proportion of pregnancies ending in abortion is about one-fourth.

The number of legal abortions reflects the number of unintended pregnancies experienced by American women. In 1978 (the latest year for which estimates have been made), there were more than three million unintended pregnancies; this figure represents 55 percent of the 5.6 million pregnancies that occurred that year. Just under half of these unintended pregnancies were terminated by abortion; the remainder resulted in births or miscarriages.[3] Thus, the abortion rate is much lower than it would be if many women did not carry unintended pregnancies to term, either by choice or because they were unable to obtain abortion services.

As Figure 1 shows, the abortion rate is higher in the United States than in the Western European countries for which accurate data are available and is lower in the United States than in Eastern European countries and Cuba. Rates are estimated to be even higher in Japan and the Soviet Union (not shown).

As shown below, the rate of increase in abortions has been declining steadily and appears to be leveling off. There was a four percent increase between 1978 and 1979, and a two percent increase between 1979 and 1980. If this trend continues, figures for 1981 or 1982 should show that the rate has stabilized.

Year	Abortion rate	% increase over previous year
1973	16.6	u
1974	19.6	18
1975	22.1	13
1976	24.5	11
1977	26.9	10
1978	28.2	5
1979	29.3	4
1980	30.0	2

Note: u = unavailable.

Much of the rise in the abortion rate and ratio in the first years after legalization, between 1973 and 1975, may be attributed to the rapid diffusion of abortion services (and of information regarding availability) to most large metropolitan areas during that period.

Since 1975, the most important factor in the abortion rate rise has probably been the increased rate of unintended pregnancy due to a widespread shift away from the use of the most effective methods of contraception. The proportion of all American women aged 15–44 using the pill is estimated to have fallen by as much as one-fourth between 1975 and 1978, and has probably declined further since.‡ Because most of the women who would previously have used oral contraceptives are undoubtedly using methods with higher use-failure rates or are using no method at all, the shift away from the pill could account for much of the increase in the national abortion rate. Other factors that may be contributing to the rising rate of unintended pregnancy—and, therefore, to the rising abortion rate—are a decrease in the use of the IUD[4] and an increase in the proportion of unmarried women who are sexually active.[5] Increased use of contraceptive sterilization,[6] on the other hand, is working to reduce the rate of unintended pregnancy. In addition, the abortion rate may be affected by changes in the proportion of women who choose to terminate unintended pregnancies by abortion, although there will be no measure of this until data from Cycle III of the National Survey of Family Growth become available.

If the U.S. abortion rate stabilizes at or near its present level, the implication is not necessarily that all women needing abortion services are able to obtain them, or that women who can obtain them are able to do so readily. There is abundant evidence that many women still find abortion services difficult or impossible to get because of the distance they live from the nearest provider, the cost, a lack of information on where and how to get an abortion and other restrictions. Plateauing of the abortion rate may, in fact, reflect a freezing of the abortion delivery system or an increase of restrictions on the provision of abortion. The data below describe the variations in abortion service availability across the United States, the diverse types of providers that represent a small subset of the medical system women generally use and the restrictions some women must contend with once they locate a provider.

Geographic Availability

Even after eight years of slow diffusion, abortion services are not uniformly available in all areas of the country. An indication of maldistribution of abortion services is the wide variation among states in the abortion occurrence rate (i.e., the number of abortions obtained in the state per 1,000 women aged 15–44 who live in the state). Although one would expect a degree of variation in abortion rates, as in birthrates, the observed range—from seven in West Virginia to 47 in Nevada—is very large, as Table 2 (page 8) shows.§ In some cases, neighboring states—Kansas and Nebraska, North Dakota and South Dakota, and New Hampshire and Vermont, for example—that are generally similar in other respects have markedly different abortion rates, apparently because of differing abortion service availability.

Past inadequacy of abortion services is reflected in the fact that states with the largest percentage increases in abortions between

*Not all states require reporting of abortions. In addition, in states that do have reporting systems, there are variations in the types of providers that must report, in the completeness of reporting by providers and in the follow-up by the health department.

†The 1980 census found about two percent more women of reproductive age than had been projected from earlier data. Therefore, the abortion rate based on the actual 1980 census count (29.4) is about two percent lower than that calculated using the number of women that had been projected (30.0). Since the rates for 1979 and earlier years were calculated using projected population estimates, the 1980 rate based on the projected population will be used for all comparisons with earlier years, although the rate based on the new census data is more accurate.

‡Pill use calculated from "OCs—Update on Usage, Safety, and Side Effects," *Population Reports*, Series A, No. 5, Jan. 1979, and AGI, *Data and Analyses for 1980 Revision of DHHS Five-Year Plan for Family Planning Services*, New York, 1981.

§Birthrates per 1,000 population in 1978 ranged from 11.9 in Massachusetts to 29.5 in Utah, a difference of a factor of 2.5, compared to a difference of a factor of 6.7 between the highest and lowest state abortion rates. (For birthrates, see: U.S. Bureau of the Census, *Statistical Abstract of the United States, 1980*, U.S. Government Printing Office, Washington, D.C., 1980.)

Table 2. Number of reported abortions by state of occurrence, 1978, 1979 and 1980; change 1978–1980; percentage change 1978–1980; and rate per 1,000 women aged 15–44, 1980

State	No. of abortions			Change 1978–1980	% change 1978–1980	Abortion occurrence rate, 1980*
	1978	1979	1980			
U.S. total	1,409,600	1,497,670	1,553,890	144,290	10	29.4
Ala.	15,120	17,590	20,780	5,660	37	23.2
Alaska	2,600	1,890	1,890	−710	−27	18.0
Ariz.	13,370	14,500	15,790	2,420	18	25.3
Ark.	5,150	6,110	6,190	1,040	20	12.3
Calif.	234,520	248,080	250,380	15,860	7	44.0
Colo.	19,800	22,420	23,140	3,340	17	31.6
Conn.	17,800	18,390	18,450	650	4	25.6
Del.	3,470	3,650	3,740	270	8	26.0
D.C.	30,850	28,670	28,520	−2,330	−8	167.8
Fla.	63,470	70,190	73,580	10,110	16	35.8
Ga.	36,080	38,760	37,890	1,810	5	28.6
Hawaii	7,090	7,600	7,960	870	12	34.5
Idaho	1,800	2,050	2,740	940	52	12.8
Ill.	70,280	70,920	69,110	−1,170	−2	26.0
Ind.	15,340	18,910	19,630	4,290	28	15.4
Iowa	7,530	9,280	9,280	1,750	23	14.3
Kans.	12,870	13,720	13,570	700	5	25.6
Ky.	12,470	12,860	12,820	350	3	15.2
La.	13,290	16,040	17,680	4,390	33	17.7
Maine	5,150	4,680	4,750	−400	−8	18.7
Md.	25,780	28,020	30,490	4,710	18	29.3
Mass.	42,610	45,110	45,590	2,980	7	33.6
Mich.	58,550	63,020	65,230	8,680	15	29.8
Minn.	17,580	19,080	19,920	2,340	13	20.8
Miss.	4,010	5,060	6,080	2,070	52	10.7
Mo.	15,570	17,740	21,620	6,050	39	19.4
Mont.	3,100	3,550	3,670	570	18	20.2
Nebr.	6,630	5,660	6,350	−280	−4	18.0
Nev.	6,060	8,200	9,170	3,110	51	47.2
N.H.	3,960	4,210	4,660	680	17	21.3
N.J.	48,040	51,230	55,460	7,420	15	32.9
N. Mex.	6,250	8,020	8,410	2,160	35	27.2
N.Y.	187,050	183,190	187,460	410	†	45.9
N.C.	30,120	30,370	31,890	1,770	6	22.9
N. Dak.	2,240	2,810	3,140	900	40	21.6
Ohio	57,140	64,380	67,140	10,000	18	26.8
Okla.	11,180	10,820	11,280	100	1	16.5
Oreg.	14,450	17,690	17,670	3,220	22	26.5
Pa.	65,150	64,920	68,910	3,760	6	26.1
R.I.	4,570	5,650	6,640	2,070	45	30.8
S.C.	13,050	13,170	13,660	610	5	18.3
S. Dak.	1,400	1,440	1,360	−40	−3	9.1
Tenn.	23,040	25,430	25,590	2,550	11	23.7
Tex.	83,280	94,080	102,000	18,720	22	30.2
Utah	3,150	3,810	4,200	1,050	33	12.4
Vt.	3,290	3,380	3,760	470	14	30.6
Va.	30,370	31,380	31,760	1,390	5	24.3
Wash.	34,490	35,580	37,030	2,540	7	37.7
W. Va.	2,840	3,100	3,000	160	6	7.0
Wis.	17,510	20,240	21,790	4,280	24	20.1
Wyo.	1,070	1,020	1,070	0	0	9.6

*Rate based on April 1, 1980, populations from U.S. Bureau of the Census, unpublished data from the 1980 census.
†Less than 0.5 percent.

1978 and 1980 tended to have low abortion rates in 1978. The number of abortions increased by at least one-third in 10 states—Alabama, Idaho, Louisiana, Mississippi, Missouri, Nevada, New Mexico, North Dakota, Rhode Island and Utah. The average abortion occurrence rate in 1978 in these states was 17.0, much lower than the average of 23.7 in all other states (not shown). In these 10 states, an average of 25 percent of women obtaining abortions traveled out of state for their procedures in 1978, compared to 15 percent of those who lived in the other 40 states.* In four of the 10 states (Alabama, Louisiana, Mississippi and Missouri), abortions occurring in clinics established since 1978 amounted to between 21 and 30 percent of the number that were performed in 1978, suggesting that the addition of new providers in these states enabled more women to terminate unintended pregnancies by abortion or to do so without traveling to other states. That the opening of a single abortion facility can influence a state's abortion occurrence rate, as happened in Mississippi, suggests that many women are unable to obtain the abortion services they want and need when these services are unavailable locally.*

The AGI has attempted to measure the availability of abortion services more directly by calculating the proportion of women of reproductive age living in counties without any abortion services. This measure is imperfect, since the existence of a single abortion facility in a woman's county of residence may not mean that the specific services she needs are available and accessible to her; conversely, many women in counties without a provider may have access to a facility in a neighboring county. Nevertheless, the absence of an abortion provider in a woman's home county suggests that abortion services are not readily available to her.

Evidence of the importance of having abortion services available locally may be found by relating the availability of abortion services in a state to the resident abortion rate (i.e., the number of abortions obtained in the state or elsewhere by state residents per 1,000 state residents).† In 1978, among the 50 states there was an extremely high correlation (0.81) between the proportion of women living in counties with any abortion services and the proportion of residents of

(Continued on page 10)

*For another study showing that abortion rates tend to rise when abortion services become available locally, see: J. D. Shelton, E. A. Brann and K. F. Schulz, "Abortion Utilization: Does Travel Distance Matter?" *Family Planning Perspectives*, 8:260, 1976.

†A later article will present resident abortion rates for each state.

(Continued from page 8)

the state who obtained an abortion.* That is, abortions were much more likely to be obtained by residents of states where most women live in counties with abortion services than by residents of states where few women live in counties with services.

Although many of the women living in unserved areas apparently are unable to obtain abortions, some are able to travel to other cities, even great distances, for abortion services. However, the need to travel, especially when long distances are involved, presents substantial disadvantages for many women: Costs are increased because of travel expenses and the possible need for overnight lodging, rapid diagnosis and treatment of postabortion complications are more difficult, and privacy is jeopardized by the need to be away from home and work for a longer period of time. If, because of distance or any other factor, the abortion is delayed until a later point in gestation, the risk of morbidity and mortality increases, [8] and the cost of the procedure may increase as well. The problems caused by distance are particularly severe for low-income women and teenagers.

Results of the 1980 survey make clear that many women live in areas that still have no abortion services available. As Table 3 shows, 78 percent of all U.S. counties have no identified abortion service provider, and about 28 percent of all women of reproductive age live in these counties.

Calculations were also made of the proportion of women living in counties without at least one facility providing 400 or more abortions during 1980, since a provider of this size is more likely to be known and accessible to the average women than is a smaller facility. In 92 percent of counties, no facility reported 400 or more abortions; 44 percent of women live in these counties.

Furthermore, since 1976 the extension of abortion services to previously unserved areas has proceeded at a slow pace, after the substantial gains that were registered between 1973 and 1976, as the table shows. The proportion of women living in unserved counties has remained virtually unchanged since 1976; the proportion living in counties without a provider of 400 or more abortions has declined slightly. (As was shown in Table 1, a similar pattern is evident in the total number of identified abortion service providers, which increased by 58 percent from 1973 to 1976, but has increased by only seven percent since 1976.)

The problem of access to abortion services is particularly severe for nonmetropolitan women, since abortion facilities are concentrated in urban areas. Almost 70 percent of nonmetropolitan women live in counties with no facility reporting even one abortion, as Table 3 shows, and 95 percent live in counties without a provider reporting 400 or more abortions. Put another way, only 4.5 percent of abortions take place in nonmetropolitan areas, although about 26 percent of women of reproductive age live in these areas (not shown). The situation has changed little since 1974, when 4.2 percent of abortions were reported in nonmetropolitan areas. Since 1978, the number of nonmetropolitan abortion providers has declined slightly, while the number of providers in metropolitan areas has continued to increase slowly.

Even in metropolitan areas, however, 13 percent of women live in counties without an abortion facility, and 26 percent live in counties without any facility reporting 400 or more abortions. Fifty-nine of the 305 SMSAs have no identified abortion provider and an additional 25 SMSAs report fewer than 50 abortions. Table 4 lists these areas. Each SMSA would have more than 400 abortions if their abortion rates approached the national average.

Map 1 (page 13) shows the availability of abortion services in each state. In 15 states, fewer than half of all women of reproductive age live in counties with an identified abortion service provider. In four states—Mississippi, North Dakota, South Dakota and West Virginia—fewer than one-quarter of such women live in counties with any provider (not shown).

Table 3. Percentage of counties with no abortion facilities and percentage of women aged 15–44 living in counties with no abortion facilities, by metropolitan status,* 1973–1980

Measure	1973	1974	1975	1976	1977	1978	1979	1980
Counties (N=3,105)								
% with no facility	83.3	80.5	78.6	77.3	76.9	77.0	77.9	77.7
Metro	56.6	51.6	49.1	47.5	46.6	46.6	46.7	46.9
Nonmetro	90.3	88.1	86.3	85.0	84.8	84.9	86.0	85.8
% without at least one facility reporting ≥400 abortions during the year	96.2	94.8	94.0	93.5	92.7	92.7	92.4	92.2
Metro	82.7	77.0	74.7	72.2	68.9	68.9	67.7	67.2
Nonmetro	99.8	99.4	99.1	99.0	98.9	98.8	98.8	98.7
Women aged 15–44† (N=50,029,000)								
% living in a county with no facility	35.0	31.3	29.2	28.0	27.6	27.7	27.9	27.9
Metro	20.0	18.2	14.8	13.9	13.3	13.4	13.1	13.3
Nonmetro	77.5	74.2	70.1	67.9	68.3	68.3	69.6	69.4
% living in a county without at least one facility reporting ≥400 abortions during the year	59.4	53.6	51.1	48.5	45.7	45.4	44.1	43.8
Metro	45.4	37.9	35.0	31.5	28.0	27.6	26.0	25.8
Nonmetro	99.0	98.0	96.6	96.5	96.0	95.9	95.5	95.0

*Data for metropolitan areas are presented for SMSAs and New England County Metropolitan Areas as defined by criteria published by the Office of Management and Budget, Oct. 1975.

†Based on 1978 population estimates.

Where Women Go for Abortion Services

While a large number of facilities—2,758—report providing abortion services, only a small fraction of these represent meaningful access to abortion services for more than a few women. The majority of abortions occur in a relatively small number of large facilities, as Table 5 (page 12) makes clear. Seventy-six percent of abortions are performed in the 459 nonhospital clinics and hospitals that serve 1,000 or more abortion patients during the year; 18 percent occur in the 38 facilities that perform 5,000 or more abortions. In many instances, the large facilities are especially effective in providing access because of their relatively low fees[9] and their visibility, due both to their size and to the fact that many of them advertise their existence and the services they offer. On the other hand, small providers also may play an important role in providing access to services in areas without other abortion facilities.

• *Hospitals.* The AGI survey identified 1,304 hospitals reporting abortions in 1980, which constitute 35 percent of all abortion providers. The average caseload of the hospitals is small, however, and only 22 percent of all abortions take place in hospitals. About one-third of the hospitals report fewer than

*Adjusted for state differences in the age and race distributions of women aged 15–44, since these factors are highly related to abortion utilization.

30 abortions each. Some report only one or two abortions, indicating that abortions are performed only in special situations and are not generally available.

Although many poor women rely on public hospitals as their primary source of health care, public hospitals are less likely than private hospitals to provide abortions, as Table 6 (page 12) shows. Only 17 percent of public hospitals, compared with 34 percent of private general hospitals, report any abortions. These differentials are evident in metropolitan and nonmetropolitan areas.

Table 7 (page 12) provides a more detailed breakdown of the types of public and private hospitals and nonhospital facilities providing abortion services.

Over time, abortion services have become slightly less available in hospitals. The proportion of short-term general non-Catholic hospitals reporting abortion services has fallen by four percentage points since 1976 (not shown). Between 1978 and 1980, while the number of nonhospital facilities has increased, the number of hospitals reporting abortions has fallen by 122, or eight percent. Among public hospitals, there has been a sharp drop in the number of military facilities reporting abortions because of restrictions imposed by federal legislation,*[10] but among other types of public hospitals the drop was only two percent (not shown). Among the private hospitals, the drop was eight percent for the voluntary (nonprofit) non-church-affiliated hospitals and six percent among the proprietary (for profit) hospitals. Abortion services declined among both proprietary and nonmilitary public hospitals. Since proprietary hospitals are believed to be less affected by public opinion than public facilities, it may be inferred that the decline in services among nonmilitary public hospitals resulted from factors affecting all types of hospitals rather than simply pressure exerted by antiabortion groups.

In fact, each year since abortion was legalized, a decreasing proportion of abortions have taken place in hospitals. As Table 8 (page 13) shows, in 1973, 52 percent of all abortions were performed in hospitals, but by 1980 the proportion had fallen to 22 percent. The actual number of abortions occurring in hospitals also dropped between 1973 and 1980, by 17 percent in public hospitals and by 10 percent in private hospitals. The table also shows the striking concomitant increase in the number of abortions performed in nonhospital facilities.

*The annual appropriations bill for the Department of Defense for FY 1979 contained a rider severely restricting the abortion coverage of CHAMPUS, the health insurance plan for military dependents and retirees.

A number of factors have encouraged the shift from hospitals to nonhospital facilities. By 1973, there had been relatively little experience with abortion, and much of the medical profession assumed that the procedure would be safest if performed in a hospital setting. As experience increased, and as vacuum aspiration replaced sharp curettage as the predominant procedure, it became evident that first-trimester abortion, when performed as an ambulatory procedure in a properly equipped nonhospital clinic or doctor's office, is at least as safe as when performed in a hospital.[11] (Other types of minor surgery are also being performed increasingly in doctors' offices and nonhospital surgicenters.) The development of the dilatation and evacuation procedure has extended to at least 16 weeks the gestation at which abortions can be performed safely in clinics.[12] Given the safety of outpatient abortions, the cost advantage of clinics became an important factor encouraging women to turn to clinics for abortion services.[13] Hospital abortions usually involve both physician fees and charges for use of the hospital facilities, and in many cases patients must pay for one or two days of hospitalization. Additional advantages of specialized high-volume abortion facilities are the expertise that results from the staff's performing a procedure many times; the attitudes and skills of the personnel, who, unlike the usual hospital staff, are selected and trained to serve abortion patients; and the availability of trained abortion counselors. While some hospitals have developed outpatient abortion clinics that have the advantages of freestanding clinics, most do not appear to be interested in developing such a facility, in part because of the public relations problems that might result.

• *Nonhospital facilities.* Most of the large abortion providers are nonhospital clinics. As noted above, 38 facilities perform 5,000 or more abortions; 34 are nonhospital clinics and four are hospitals. Similarly, 345 of the 421 facilities that report 1,000 to 4,999 abortions are nonhospital facilities.

The availability of nonhospital abortion services has increased somewhat since 1978. As was shown in Table 7, the total number of nonhospital facilities providing abortions has grown by 11 percent since 1978. Perhaps more important to women seeking abortions, the number of clinics serving 400 or more abortion patients has grown by 18 percent, and the number of physicians' offices reporting this many abortions has risen by 22 percent. Although many new large facilities are located in areas with existing providers, or were small facilities whose caseloads have increased, others have opened in previously unserved areas and represent a continuing

Table 4. SMSAs reporting fewer than 50 abortions, by state, 1980

State and SMSA	State and SMSA
Alabama	**North Dakota**
Anniston*	Bismarck
Florence*	Fargo
Gadsden	
	Ohio
Arkansas	Canton*
Fayetteville*	Hamilton*
Ft. Smith*	Lima
Texarkana*	Lorain
	Mansfield
California	Newark
Visalia*	Springfield
	Steubenville
Colorado	
Pueblo*	**Oklahoma**
	Enid
Florida	Lawton
Bradenton*	
Ft. Walton Beach*	**Pennsylvania**
Panama City*	Altoona*
	Erie
Georgia	Johnstown*
Athens*	Lancaster
	Sharon*
Illinois	State College
Bloomington	
Decatur	**South Carolina**
Kankakee	Anderson
Springfield	Florence
	Rock Hill
Indiana	
Anderson	**South Dakota**
Elkhart	Sioux Falls
Kokomo	
Lafayette	**Tennessee**
Muncie	Clarksville
Terre Haute	
	Texas
Iowa	Abilene*
Dubuque	Amarillo*
	Bryan
Kentucky	Galveston*
Owensboro	Laredo
	Longview
Louisiana	Midland
Alexandria	San Angelo
Lafayette	Sherman
Lake Charles	Tyler
Monroe	Victoria
	Waco
Maine	
Lawiston*	**Utah**
	Provo
Michigan	
Battle Creek*	**Virginia**
Bay City*	Danville
	Washington
Minnesota	Bremerton
St. Cloud	Richland
Mississippi	**West Virginia**
Pascagoula	Huntington
	Parkersburg
Missouri	
Joplin	**Wisconsin**
St. Joseph	Appleton*
	Janesville
New Jersey	Kenosha
Vineland	LaCrosse*
	Sheboygan
New Mexico	Wausau
Las Cruces*	

*Reported between one and 50 abortions in 1980. SMSAs without an asterisk did not report any abortions in 1980.

Table 5. Number and percentage distribution of abortion service facilities and abortions, by type of facility, according to caseload, 1980

Caseload*	Facilities						Abortions					
	Total		Hospital		Nonhospital		Total		Hospital		Nonhospital	
	N	%	N	% of total	N	% of total	N	%	N	% of total	N	% of total
Total	2,758	100	1,504	55	1,254	45	1,553,890	100	341,030	22	1,212,860	78
<30	650	24	520	19	130	5	6,880	†	5,210	†	1,670	†
30-390	1,352	49	788	29	564	20	179,280	12	95,540	6	83,740	5
400-990	297	11	116	4	181	7	189,090	12	68,440	5	120,650	8
1,000-4,990	421	15	78	3	345	12	905,910	58	142,240	9	763,670	49
≥5,000	38	1	4	†	34	1	272,730	18	29,600	2	243,130	16

*In this and subsequent tables, caseloads are rounded to nearest 10. †Less than one percent.

Table 6. Percentage of short-term general non-Catholic hospitals providing abortions, by metropolitan status, according to hospital type, 1980 (number of hospitals in each cell shown in parentheses*)

Metropolitan status	Hospital type					
	Total		Public		Private	
U.S. total	27	(5,538)	17	(2,118)	34	(3,420)
Metro	42	(2,700)	32	(680)	45	(2,020)
Nonmetro	13	(2,838)	10	(1,438)	16	(1,400)

*Numbers of hospitals are based on a special tabulation of the 1978 American Hospital Association (AHA) hospital survey. From 1978 to 1980, the number of public hospitals declined by 0.1 percent and the number of private hospitals declined by 0.5 percent. (See: AHA, *American Hospital Association Guide to the Health Care Field, 1981 Edition*, Chicago, 1981, Table 1.)

slow diffusion of abortion services to an ever larger proportion of the population.

Many of the clinics offering abortion services cannot be characterized accurately as abortion clinics. Twenty percent of those responding to the AGI survey describe their facilities as general ob-gyn practices that include abortion among other services provided, four percent offer general fertility-related services and six percent say they provide general medical care (see Table 9, page 14). Another four percent, classified as "other," are mainly surgical practices or multispecialty groups. While nonabortion services are more commonly offered by the clinics providing smaller numbers of abortions, 18 percent of even the largest abortion providers, those reporting 1,000 or more abortions, describe their primary services as other than abortion. Although it may be easier for women seeking abortions to find out about specialized abortion clinics, the existence of abortion services in a variety of types of clinics in a single metropolitan area undoubtedly facilitates their access to abortion services.

Among the physicians providing fewer than 400 abortions in their offices, almost all—87 percent—are described as having ob-gyn practices (not shown). Only six percent have general medical practices. However, general practitioners performing abortions may be less well covered by the AGI survey than are obstetrician-gynecologists.

The AGI survey identified 723 physicians' practices where office abortions are performed; this number represents only a small proportion of the 18,000 obstetrician-gynecologists in private practice in the United States.[14] The questionnaire that went to private medical practices asked how many physicians in the practice provide abortions. Most practices (63 percent) report that only one physician performs abortions, although the numbers range as high as eight or more. Thus, assuming that the numbers of physicians per practice are similar among respondents and nonrespondents, it can be estimated that the number of physicians reporting abortions in their offices is 1,200. This estimate is a minimum figure, since it is known that the survey misses some physicians who perform small numbers of abortions in their offices. Allowing for a possible undercount, about one in 10 obstetrician-gynecologists in private practice perform abortions in their offices. Thus, relatively few women are able to obtain abortion services in the offices of their private gynecologists or obstetricians.

Restrictions on Services

Even a woman who lives in an area with an abortion provider may not be able to obtain the abortion services she needs locally. There are a number of restrictions on services that preclude many women from utilizing a particular facility or even any facility in an area or state. Some of these restrictions result from legislation or from provider policies intended to limit the number of abortions; others represent limitations of the resources and capabilities of providers. Among the restrictions are parental notification and consent requirements for minors, Medicaid funding limitations, lack of outpatient abortion services in many hospitals where abortions are performed, the policy of some providers not to accept new patients seeking abortions and limitation of abortion to early gestational ages.

• ***Parental notification and consent.*** Parental notification and parental consent requirements can pose a significant obstacle for minors seeking abortion services. These requirements have been imposed both by individual abortion providers and by state and local legislation, although the constitutionality of such legislation is being challenged. According to a survey of abortion providers conducted by the AGI,[15] 38 percent of hospitals and 19 percent of clinics have parental consent or notification requirements for minors under age 18; and 48 and 38 percent of hospitals and clinics, respectively, have such requirements for those under 15. It is estimated that 37 percent of teenagers under 18 who obtained legal abortions in 1978 did so in hospitals and clinics with parental consent or notification requirements.

In Maryland, Montana and Utah, laws are in effect that require parental notification;

Table 7. Number of facilities providing abortion services, by type of facility, 1978, 1979 and 1980, and change 1978–1980

Facility	1978	1979	1980	Change 1978–1980	
				N	%
All facilities	2,753	2,734	2,758	5	*
HOSPITALS					
Total	1,626	1,526	1,504	−122	−8
Public	390	363	357	−33	−8
Military	35	9	8	−27	−77
Other federal	3	3	3	0	0
State	43	41	41	−2	−5
Hospital district	126	136	136	10	8
County	113	105	102	−11	−10
City; city/county	70	69	67	−3	−4
Private	1,236	1,163	1,147	−89	−7
Voluntary, church	72	75	70	−2	−3
Voluntary, other	919	858	846	−73	−8
Proprietary	245	230	231	−14	−6
NONHOSPITAL FACILITIES					
Total	1,127	1,208	1,254	127	11
Clinics	478	511	531	61	13
Caseload<400	105	111	102	−3	−3
Caseload≥400	365	400	429	64	18
MDs' offices	667	697	723	66	10
Caseload<400	550	573	582	42	8
Caseload≥400	107	124	131	24	22

*Less than one percent.

and Louisiana, Massachusetts, Minnesota and North Dakota require parental notification or consent, with the provision that a minor may seek the authorization of a judge as an alternative to parental involvement. Court authorization is granted if the judge determines that the teenager is mature enough to make an informed decision or, if she is not, that the abortion would be in her best interest. Although in Massachusetts almost all minors who seek court permission are granted it, the procedure subjects them to stress and anxiety, and may inhibit some from seeking abortion services.[16]

To assess the probable impact of parental notification and consent requirements, the AGI study referred to earlier[17] also surveyed minors obtaining abortions in a national sample of abortion clinics. Fifty-five percent of respondents said that one or both parents knew about their abortions, but 23 percent said that they would avoid having a legal abortion if their parents had to be told. (They were not asked about the option of obtaining court approval of the abortion without parental knowledge.) Of those who said that they would not have a legal abortion, 39 percent said they would have a self-induced or illegal abortion; 39 percent said that they would continue their pregnancies; nine percent, that they would leave home; 13 percent did not know what they would do.

A similar study found that three-quarters of a sample of 163 Minnesota teenagers under age 18 who were obtaining abortions had not told one or both parents about their abortions and therefore would be affected by a law requiring the consent of both parents.[18] Furthermore, 40 percent thought they could not get the consent of both parents and 42 percent said they would not get a legal abortion if parental notification were required. Those who would not seek a legal abortion under parental notification requirements said they would go to another state for an abortion (44 percent), continue the pregnancy (29 percent), leave home (16 percent) or seek an illegal abortion (11 percent).

• *Medicaid funding restrictions.* For poor women, the cost of an abortion may be a serious impediment to the utilization of abortion services. Until late in 1977, when the Hyde Amendment severely limited federal participation in Medicaid funding of abortions, Medicaid paid for abortions for significant numbers of poor women in many states. Since 1977, the number of Medicaid-funded abortions has been reduced as a consequence of the Hyde Amendment and of the policy of most states to adopt similar restrictions. The number of Medicaid abortions fell from 295,000 in FY 1977 to 194,000 in FY 1978 and 209,000 in FY 1979.[19] The number would have fallen more had a few of the states serving large numbers of Medicaid patients—notably California and New York—not continued to pay for Medicaid abortions. In addition, many of the states that adopted the restrictions had, in fact, been paying for abortions for only a fraction of the Medicaid-eligible women estimated to be in need of abortion services.*

As a result of the cutbacks in public funding of abortion, many poor women have found access to abortion services more difficult or impossible. The most extensive study of the importance of Medicaid funding found that between 18 and 23 percent of Medicaid-eligible women who would have obtained abortions when Medicaid funding was available instead carried their pregnancies to term when that funding was cut off.[20]

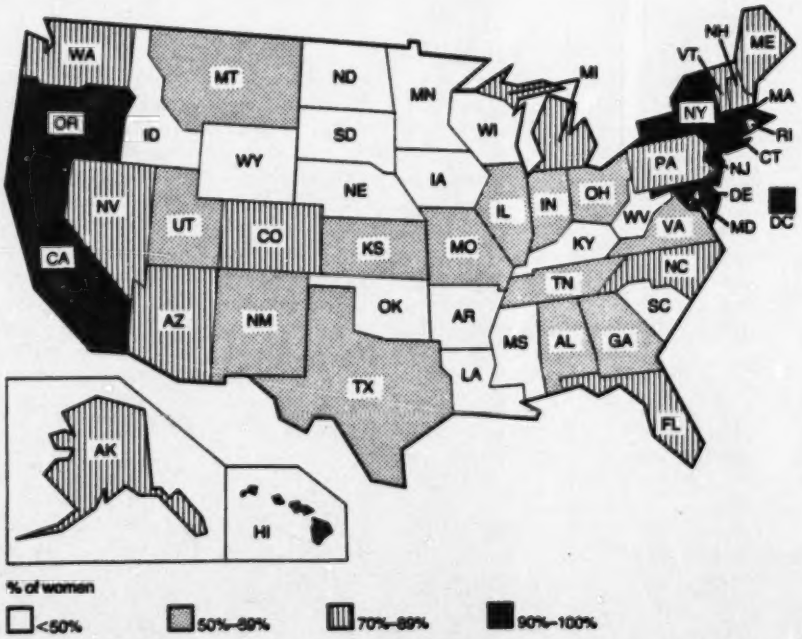
As of December 1981, 14 states and the District of Columbia were continuing to fund medically necessary abortions under Medicaid, even though federal funds for most of these abortions are no longer available. It is the policy of nine states—Alaska, Colorado, Hawaii, Maryland, Michigan, New York, North Carolina, Oregon and Washington—

Table 8. Number and percentage distribution of reported abortions, by type of facility,* 1973, 1978, 1979 and 1980

Type of facility	No. of abortions				% distribution			
	1973	1978	1979	1980	1973	1978	1979	1980
U.S. total	744,600	1,409,600	1,497,670	1,553,890	100	100	100	100
Hospitals	385,920	350,520	347,970	341,030	52	25	23	22
Public	83,110	76,430	73,150	68,660	11	5	5	4
Private	302,810	274,090	274,820	272,370	41	20	18	18
Nonhospital facilities	358,680	1,059,080	1,149,700	1,212,860	48	75	77	78
Clinics	343,470	998,850	1,086,920	1,145,090	46	71	73	74
Physicians' offices	15,210	60,230	62,780	67,770	2	4	4	4

*In this and subsequent tables, physicians' offices reporting 400 or more abortions a year are classified as clinics.

Map 1. Percentage of women aged 15–44 living in counties with abortion facilities, by state, 1980



*For details see: AGI, *Abortions and the Poor: Private Morality, Public Responsibility*, New York, 1979, p. 14.

Table 9. Percentage distribution of responding nonhospital clinics performing abortions, by types of services provided, according to caseload, 1980

Types of services provided	% of clinics, by caseload			
	Total	<400	400–990	≥1,000
	(N= 431)	(N= 73)	(N= 69)	(N= 289)
Primarily or exclusively abortions	66	14	53	82
General ob-gyn services	20	46	25	13
General fertility services	4	3	10	3
General medical care	6	23	9	1
Other	4	14	3	1

and of the District of Columbia to fund medically necessary abortions. California and Massachusetts are continuing to fund medically necessary abortions under final court order of their state supreme courts, which have held that such funding is required under the state constitution. Connecticut, New Jersey and Pennsylvania are under interim court order by state courts to fund abortions under Medicaid.[21]

Table 10. Percentage of responding hospital abortion facilities that serve new self-referred patients, by caseload, according to hospital type, 1980 (number of hospitals in each cell shown in parentheses)

Caseload	Hospital type					
	Total		Public		Private	
Total	26	(861)	34	(205)	23	(656)
<400	19	(759)	26	(180)	17	(579)
≥400	72	(102)	88	(25)	66	(77)

Table 11. Percentage distribution of responding physicians' practices reporting office abortions, by type of referrals accepted, according to caseload, 1980

Type of referral	% of practices, by caseload			
	Total	<30	30–390	≥400
Accept referrals from other physicians or facilities	(N= 641)*	(N= 108)	(N= 415)	(N= 118)
Yes, routinely	93	81	95	98
Yes, under special circumstances	5	12	4	0
No	2	7	1	2
Accept new self-referred patients	(N= 636)	(N= 108)	(N= 412)	(N= 116)
Yes, routinely	91	80	93	96
Yes, under special circumstances	6	12	5	3
No	3	8	2	1
Total	100	100	100	100

*Number of practices responding to questionnaire.

Since Medicaid is a joint federal-state program, Medicaid-eligible women seeking health care such as abortion services must obtain those services in their home state. Their ability to travel across state lines to avoid restrictions such as parental notification or consent requirements or gestational age limitations is therefore curtailed, and they are affected by problems of service availability and accessibility to a greater extent than are higher income women.

• *Hospital outpatient abortion services.* Another factor affecting the cost of abortions is the dearth of outpatient abortion services in hospitals. In many hospitals, abortions are available only as costly inpatient procedures that involve payment usually for at least one day of hospitalization as well as operating room and physician charges. These fees, added to time lost from work or other responsibilities, represent a formidable financial obstacle for women with limited incomes.

Data available from 60 percent of hospitals (which reported 54 percent of all hospital abortions) indicate that only 55 percent of hospital abortion providers perform any outpatient abortions, and 55 percent of hospital abortions occur as outpatient procedures.

• *Acceptance of self-referred patients.* Because of the way U.S. hospitals are structured, most do not provide services directly to the public.* They simply permit their facilities to be used by attending physicians who provide medical care (sometimes including abortion services) to their own patients. This being the situation, even if a woman lives in an area with a hospital where abortions are performed, the chances are that she will not be able to arrange directly with the hospital to obtain an abortion. She will usually be told to seek this care from a private physician or, at most, will be referred to a specific physician who may be willing to perform an abortion in the hospital.

In the 1981 AGI survey, hospitals were asked whether they accept self-referred abortion patients for service. Of the hospital providers answering the question, only 26 percent responded in the affirmative, as Table 10 shows. The proportion is somewhat higher for public hospitals (34 percent) than for private hospitals (23 percent). Among providers performing 400 or more abortions a year, the majority (72 percent) accept self-referred patients; most of these presumably have organized abortion clinics. A large majority of hospital providers, however, have small caseloads (87 percent report fewer than 400 abortions in 1980), and only 19 percent of these accept self-referred patients. Often, then, a women cannot arrange directly with a hospital to obtain an abortion but must have as an intermediary an attending physician willing to accept her as a patient.

Table 12. Percentage distribution of abortion facilities, by the maximum gestation at which the facility will provide abortions, according to type of facility, 1980

Maximum gestation (weeks LMP)	All facilities (N= 1,918)	Hospitals (N= 824)	Clinics (N= 565)	MDs' offices (N= 529)
5–6	3	3	*	7
7–8	12	11	2	22
9–10	15	15	9	23
11–12	37	34	43	35
13–14	12	5	27	9
15–16	4	4	8	1
17–20	11	18	8	3
≥21	6	10	3	*
Total	100	100	100	100

*Less than one percent.

Most physician facilities, on the other hand, accept self-referred abortion patients. As Table 11 shows, of the practices responding to the survey question, 93 percent routinely accept referrals from other physicians or facilities and 91 percent accept new self-referred patients. Even among practices that perform fewer than 30 office abortions per year, 80 percent accept new self-referred patients. It can be assumed that nearly all clinics offering abortion services accept self-referred patients, with the exception of group health plans serving only enrolled members.

• *Limitations on gestation.* If a woman does not discover her pregnancy early in gestation, or if she delays seeking an abortion, she will find that she is limited in the facilities willing to provide abortion services to her. Even within the first trimester of pregnancy, some providers restrict abortions to women whose pregnancy has lasted less than 10, eight, or even six weeks from the last menstrual period (LMP).

Respondents were asked, "What is generally the maximum gestation (in weeks since last menstrual period) of abortions provided in the hospital [in your facility, in your office]?" Since some responses were outside the expected range, a small sample of facilities were resurveyed to verify their answers. This check revealed that some respondents had reported weeks of conceptional age rather than weeks since LMP. In addition, some respondents, particularly those in the medical records departments of hospitals, had

*Some hospitals do have emergency rooms that respond directly to the public. And some have a variety of clinics, such as well-baby and prenatal clinics, that are open, in general, to publics within their own catchment area.

misunderstood the question or the facility's policy. However, the results are useful in that they reflect the general pattern of policies regarding gestation.

The responses suggest that many facilities restrict their services to early gestations. Fifty-two percent of the physicians and 29 percent of the hospitals ordinarily provide abortions only to women at 10 or fewer weeks' gestation (see Table 12). Some of the physicians apparently perform only menstrual regulation, which is included in the definition of abortion used by the AGI survey—seven percent of responding physicians report providing abortions only up to six weeks LMP. Relatively few physicians—about 13 percent—perform abortions in their offices past 12 weeks LMP. A very few physicians perform abortions in their offices past 16 weeks; some of these may initiate instillation abortions in their offices to be completed in a hospital.

Twenty-seven percent of the clinics say their cutoff point is 13 or 14 weeks. Most of these consider abortions at 14 weeks LMP to be first-trimester procedures, since this age equals 12 weeks postconception. Nineteen percent of clinics and 32 percent of hospitals perform abortions past 14 weeks LMP.

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Document #8

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REGULATION OF ABORTION SERVICES — FOR BETTER OR WORSE?

Two different approaches are currently being used in the United States to limit the availability of legal abortions — restriction of public funds for abortion[1] and regulation of conditions under which abortions can be performed. Regarding the latter, legislation has been introduced at local, state and national levels to regulate abortion services. The prototype for this legislation was initially introduced as a city ordinance in Akron, Ohio.[2] The alleged purposes of this kind of legislation are to provide more comprehensive information for women considering termination of pregnancy and thus allow "informed consent" and, secondly, to guard the health of women who choose to obtain an abortion by providing safer conditions for the procedure.

One or more laws like that in Akron have been introduced in at least 26 states and nine municipal areas in the country. Moreover, a proposed United States Senate Bill ("Alternatives to Abortion Act of 1978") defines the counseling procedures to be used in abortion facilities.[3] Finally, amendments to forbid abortion counseling and to require parental notification have been proposed for the Title X Family Planning Bills in the past two sessions of Congress.[4] Thus, although initiated as a local ordinance, the regulations in Akron may have a national impact.

In this article, we summarize the content and scope of these regulations, describe the problems arising from their informed-consent provisions, discuss their possible consequences on health and suggest ways to determine their actual effects.

Content and Scope of Akron Regulations

This legislation does not involve either the funding of legal abortions or the provision of other health services. Rather, the Akron statute specifies the type of information that must be transmitted to every woman seeking an abortion, and it also dictates the medical practices that must be followed by every facility providing abortions. Moreover, it applies to all women seeking abortions and to all abortion facilities operating within the specific jurisdiction of the local or state government where the legislation has been proposed; unlike the funding restriction, it does not primarily apply to women in low-income groups.

The Akron-type regulations contain five main provisions that affect the delivery of abortion services:

Informed Consent

The prototype Akron regulation[2] requires that abortion be described to the woman as a "major surgical procedure" and mandates that she be warned of the variety of serious physical and mental complications that may result, including "sterility, miscarriage and prematurity in subsequent pregnancies." No description of the risks of the alternatives to legally induced abortion is required. Moreover, according to the regulation the woman must be given a detailed description of the anatomic and physiologic characteristics of the fetus at the gestational age when the abortion is to be performed.

Waiting Period

The Akron ordinance[2] requires at least a 24-hour waiting period between obtaining the consent of the woman after counseling and performing the abortion. Other statutes require waiting periods of up to 48 hours.[3]

Parental Notification

The Akron ordinance[2] requires that, if the pregnant woman is under 18 years of age and unmarried, her parents or guardian must be notified at least 24 hours before the procedure. If they cannot be located, a 72-hour waiting period is required to allow a certified notification to reach their last known address.

Abortion Methods

Although the Akron ordinance does not attempt to regulate the method of abortion, similar laws have proscribed the use of agents such as hypertonic saline or hyperosmolar urea for instillation abortions because of their adverse effects on the fetus in utero.[5]

Abortion Facilities

The Akron ordinance requires all abortions to be performed in a hospital after 12 weeks of gestation.

Problems in the Information Provided to Obtain Informed Consent

Securing the patient's informed consent for any medical or surgical treatment requires providing accurate and complete information about the treatment itself, its alternatives, its benefits and its risks.[7,8] Although the Akron requirements are supposedly intended to educate the patient, the risks associated with the procedure are overstated, a description of the alternatives is neglected and there is a bias in favor of continuation of the pregnancy.

Like any operative intervention, induced abortion has definite risks, but most physicians would disagree with the idea of labeling an abortion a "major surgical procedure." The term "major surgery" is so vague that members of the American College of Surgeons are unable to agree on an adequate definition and have not used it for the past decade.[9] Moreover, the American College of Obstetricians and Gynecologists has specifically referred to dilatation and curettage (the most common method of abortion) as "minor gynecologic operations."[10] Underscoring this point, the Patient Information Booklet prepared by the Com-

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mittee on Patient Education of the American College of Obstetricians and Gynecologists states that "elective termination of pregnancy is a remarkably safe operation."[11]

Comparative mortality statistics reflect the relative safety of legally induced abortion. The rate of death from legally induced abortion is three per 100,000 procedures — a rate below that in other common operations, such as tonsillectomy.[12] Moreover, abortions performed before the 13th week of pregnancy carry a risk of death similar to that of the intramuscular injection of penicillin as a treatment for gonorrhea.[13] Thus, the use of the term "major surgery" to describe induced abortion to the patient is misleading.

The main problem of the Akron regulation, however, is its failure to discuss the alternatives to abortion fully. For a pregnant woman considering abortion, the alternative to termination of the pregnancy is continuation. In terms of risk of death, termination of the pregnancy before 16 weeks of gestation is seven times safer than continuation of the pregnancy to term, even after one controls for age and race.[14] Moreover, continuation results in an estimated 10 to 15 per cent incidence of abdominal operations such as cesarean section,[15] whereas legal abortion results in abdominal operations in only 0.1 to 0.2 per cent of cases[14]; thus, the risk of these complications is 50 to 150 times higher if a woman continues her pregnancy.

The Akron ordinance also exaggerates the psychologic sequelae of abortion. Although most women experience some psychologic reactions to terminating a pregnancy, these reactions are generally not as frequent or severe as the psychologic effects of continuing an unplanned or unwanted pregnancy.[11]

In addition to amplifying the short-term risks associated with abortion and ignoring those associated with continuation of a pregnancy, the Akron regulation misrepresents the possible long-term complications. Adverse outcomes of pregnancies months or years after an induced abortion are presented to the patient as if they had been proved, without considering the conflicting conclusions in the many published studies.[16] Recent reports from the World Health Organization[17] and Kaiser-Permanente, the latter to be found in the paper by Harlap and her colleagues elsewhere in this issue, have suggested that the degree of dilatation and the method of abortion may be important factors in the outcome of future pregnancies. These data imply that suction curettage, the procedure used for over 90 per cent of abortions in the United States,[20] presents little or no threat to future pregnancies. Other published studies in this country[21,22] have shown no association between induced abortions and outcome of subsequent pregnancies. Thus, the required explanations distort the known long-term risks associated with the most common abortion procedure in the United States.

The required description of fetal development during the counseling session before abortion does not pertain directly to the abortion procedure and represents an attempt to bias the patient to choose continuation of the pregnancy over termination. Fetal morphology is rarely relevant to a woman obtaining an abortion, since she will probably not have the opportunity or desire to view any fetal tissue. Instead, this description is likely to increase the anxiety and guilt feelings of women, who rarely take lightly the decision to terminate a pregnancy and are already susceptible to these emotions; psychologic trauma may result.[23,24]

Possible Consequences

Delaying an abortion adds directly to the risks of complications and death for the pregnant woman.[14,25] Although the one- to two-day delay required by the regulations may not seem very long, this time interval is often expanded because of the woman's work or school schedule, the facility's backlog in appointments or the facility's system of scheduling abortions only on specific days.[26]

Provisions for parental notification create additional delays for many pregnant teen-agers because anxiety about informing their parents leads to conflict in decision making.[27] Teen-agers as a group already obtain abortions later in gestation than do older women,[14] and fear of telling their parents, even without this requirement, has an important role in this delay.[27]

The most important risk variable in the morbidity and mortality associated with abortion is gestational age.[25] Between seven and 20 weeks of gestation, the risk of complications increases approximately 20 to 30 per cent[25] and the risk of death increases approximately 50 per cent, each week that the abortion is delayed.[14] Therefore, any action that results in delaying the abortion adds a small but definite increase in the risk of morbidity and mortality to the pregnant woman. Rather than contributing to the safety of the abortion procedure for the woman, the waiting period and parental-notification provisions actually add to its dangers.

Current data show that some agents, such as hypertonic saline or hyperosmolar urea, that have been restricted by some regulations may involve less risk to the woman than do other agents, such as prostaglandins, that have no documented effect on the fetus.[28] Thus, requiring the use of nonfeticidal agents may pose a greater threat to the health of the woman undergoing the abortion than would other methods to terminate the pregnancy.

Comparative data are not available to use in evaluating the requirement that all abortions occurring after 12 weeks of gestation be performed in a hospital. At 12 weeks or less, death-to-case rates are

similar in hospitals and other facilities.[29] Moreover, case-series reports have documented that some operators can safely perform uterine-evacuation procedures at 13 to 16 weeks in ambulatory clinics,[30,31] thus decreasing the cost and inconvenience to the patient and eliminating the unnecessary use of hospital beds. On the basis of these favorable reports, the Planned Parenthood Federation of America has advanced the gestational age limit to 18 weeks in its ambulatory clinics. The requirement that all abortions after 12 weeks of gestation be performed in a hospital will directly increase the expense and inconvenience to the woman, without making any evident contribution to the safety of the procedure.

Approaches to Monitoring the Effects of the Regulations

Several approaches can be used to determine whether regulations like those in Akron will have any impact on abortion services.

Surveillance of the Number of Women Obtaining Legally Induced Abortions

Annual and seasonal trends in the number of women obtaining legally induced abortions may indicate whether provisions for informed consent or parental notification have dissuaded women from seeking legally induced abortions.

Surveillance of the Number of Live Births

Annual and seasonal patterns in live births approximately six months after the enactment of regulations on abortion may indicate whether women are continuing their pregnancies to term, rather than terminating them by legally induced abortion.

Surveillance of the Characteristics of Women Obtaining Legally Induced Abortions

Changes in the age, race or marital status of women seeking abortions may indicate population groups that are being differentially affected by the regulations; for example, the parental-notification requirement may influence the proportion of teenagers who seek and obtain legally induced abortion.

Surveillance of the Characteristics of Women Giving Birth

Likewise, any changes in the age, race or marital status of women giving birth approximately six months after the enactment of regulations may indicate population groups that are continuing their pregnancies to term.

Surveillance of Gestational Age in Legally Induced Abortions

The gestational age at the time of the abortion may be affected by the mandatory waiting period; gestational age has proved to be the most sensitive indicator of the impact on health of restricting public funds for abortion.[32]

Surveillance of Complications

The number of complications after legally induced abortions may increase if the regulations cause women to delay abortions or cause physicians to use less safe methods. Likewise, the number of complications from illegal abortions may increase if the regulations lead a sizable proportion of women to seek abortions from persons who are not physicians. Alternatively, if a large proportion of women continue their pregnancies to term and the number obtaining abortion declines, the number of complications from abortion will decline as well.

Detailed Interviews

In-depth interviews with women who request abortions may determine whether the informed-consent provisions have affected the decision. Their responses and their postabortion adjustment can be compared with those of women outside the jurisdictional range of the regulations, to learn whether there are measurable differences.

The above suggestions represent basic epidemiologic approaches to monitoring the impact of any change in public policy on health in the community where the policy is instituted. Ideally, the community will already have surveillance mechanisms to allow temporal comparisons before and after the enactment of regulations like those in Akron. At a national level, the Center for Disease Control has been monitoring the number and characteristics of women obtaining legally induced abortions since 1969. This surveillance has allowed us to evaluate the effects of the many legislative and judicial decisions affecting abortion. We will use similar approaches to determine whether the proposed regulations have a national impact on health.

Conclusion

The issue of induced abortion raises profound ethical questions. Indeed, the controversial nature of the subject is one reason why more is known about the epidemiology of induced abortion than any other surgical procedure. The data do not answer society's dilemma, but they may be helpful to the woman attempting to choose whether to terminate or continue an unplanned pregnancy. Information should be

presented in a neutral manner, without overtones favoring either termination or continuation of the pregnancy. No woman should be persuaded to have an abortion if she does not want one; neither should she be persuaded to continue her pregnancy if she would rather terminate it.

Current state and local statutes that seek to regulate abortion under the guise of ensuring adequate patient education or improving the safety of the procedure or both could have the opposite effects. First of all, patients will be given incomplete and inaccurate information. Secondly, they will be required to delay the abortion procedure and thereby increase the associated risks. Finally, at later gestational ages, particular abortion methods that are not necessarily the safest for the woman will be mandated. The effect of these regulations could be to endanger rather than protect the health of American women who seek to end unwanted pregnancies.

WILLARD CATES, JR., M.D., M.P.H.
JULIAN GOLD, M.D.
RICHARD M. SELIK, M.D.

Center for Disease Control
Atlanta, GA 30333

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Document #9

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10 Dilatation and Evacuation

David A. Grimes
Willard Cates, Jr.

Three general approaches exist for emptying the uterus during the second trimester of pregnancy: hysterotomy, induction of labor, and dilatation and evacuation (D&E). Each of these methods of abortion shares two features: 1) a portal of exit, and 2) expulsive or tractile force on extraction to evacuate the uterine contents.

With hysterotomy, the physician creates a surgical opening in the uterus, manually empties the cavity, and repairs the wound. Because of high morbidity and mortality, prohibitive cost, and prolonged recuperation, hysterotomy has been virtually abandoned as a primary abortion method in the United States.[1]

Induction of premature labor attempts to generate expulsive forces which enlarge the natural anatomic opening of the uterus as well as expel the products of conception. Chemical insults to the feto-placental unit or administration of prostaglandins initiate uterine contractility in the second trimester. Teleologically, however, the uterus has evolved to retain its contents tenaciously at this stage of pregnancy, while reserving the capacity to expel defective pregnancies in

the first trimester and viable fetuses later on in the third. Thus, the second trimester is the least physiologic time during pregnancy for the uterus to empty itself.

Induction of labor in the second trimester often is slow, unpredictable, and painful. In addition to the side effects and hazards associated with the abortifacient agents themselves, women undergoing second-trimester abortion by labor induction also incur risks generally associated with parturition, such as amniotic fluid embolism.[2]

Dilatation and evacuation incorporates certain advantages of hysterotomy and labor induction. The principal advantage D&E shares with hysterotomy is that the evacuation procedure is brief and definitive; like abortion by labor induction, D&E uses the dilated cervix as the portal of egress. Traction (rather than expulsion) is the means by which the cavity is evacuated. D&E thus provides a faster, safer, and more comfortable abortion than alternative methods. This chapter will document the use of second-trimester D&E in the United States, describe current techniques, review the safety of the method, and then compare D&E with its alternatives.

USE OF SECOND-TRIMESTER DILATATION AND EVACUATION IN THE UNITED STATES

Dilatation and evacuation has become one of the two most frequently used methods of abortion in the second trimester. According to data provided to the Center for Disease Control (CDC) by 28 states,[1] D&E accounted for 38.7% of all abortions in 1977 at ≥ 13 weeks' gestation (Table 10-1). Intrauterine saline instillation accounted for 38.3%, while intrauterine prostaglandin $F_2\alpha$ ($PGF_2\alpha$) administration accounted for 16.6%.

Table 10-1
Reported Legal Abortions at ≥ 13 Weeks' Gestation by Type of Procedure,* United States, 1977

Type of Procedure	Number	%
Dilatation and evacuation	17,590	38.7
Intrauterine saline instillation	17,441	38.3
Intrauterine prostaglandin instillation	7534	16.6
Hysterotomy/hysterectomy	399	0.9
Other	2170	4.8
Unknown	367	0.8
Total	45,501	100.0

*Based on data from 28 states; excludes abortions with gestational age not specified.
Source: Center for Disease Control, *Abortion Surveillance 1977*, Atlanta, issued September, 1979, Table 18.

In 1977, D&E was the predominant method of abortion in the 13- to 15-week interval (73.3%). Both saline and $PGF_2\alpha$ instillation were used more frequently in the 16- to 20-week interval (50.1% and 25.7%, respectively), with D&E accounting for only 16.7% of cases. At 21 weeks' gestation, saline instillation remained the predominant method (64.3%), with D&E and $PGF_2\alpha$ responsible for nearly equal proportions (12.7% and 12.6%, respectively). The predominance of D&E in the 13- to 15-week interval may be due in large part to the technical difficulty of performing an amniocentesis for instillation of abortifacients until the uterus is approximately 16 weeks in size.

CURRENT TECHNIQUES OF SECOND-TRIMESTER DILATATION AND EVACUATION

Although the upper gestational age limit for D&E abortions may be as high as 24 weeks (Table 10-2), the majority of these operations take place earlier in the second trimester (Table 10-3). The predominance of earlier second-trimester D&E abortions reflects the gestational ages at which women request abortion (Figure 10-1). Adherence to a 12-week limit for curettage abortions artifactually skews the gestational age distribution of women obtaining second-trimester abortions.[3] For women requesting abortion at 13- to 15-weeks' gestation, use of D&E obviates the need for costly and hazardous delays until 16 weeks or later for amnioinfusion abortion.[4] In general, the incidence of second-trimester abortion should be inversely proportional to gestational age, with the exception of small but important numbers of abortions which occur late because of the need to obtain antenatal diagnoses of fetal defects.

Second-trimester D&E abortions are performed on an outpatient basis in both hospitals and free-standing clinics (Table 10-2). Low morbidity rates have been reported from both types of facilities, and no presently available data support the suggestion to limit performance of such abortions to hospitals (Table 10-3). One clinic[5] has challenged a state regulation restricting abortions beyond 12 weeks' gestation to hospitals. In 1979 the National Medical Committee of Planned Parenthood Federation of America authorized performance of second-trimester D&E abortions in nonhospital facilities of selected affiliates.

Many physicians performing second-trimester D&E abortions do not routinely obtain ultrasound estimates of gestational age. Rather, ultrasonography is reserved for clinical indications such as marked discrepancies between menstrual history and estimated uterine size. Other physicians routinely use ultrasound to corroborate gestational age for those women near the upper gestational age limit for D&E abortions. Still others use this diagnostic examination for all

Table 10-3
Studies of Dilatation and Evacuation Procedures, United States

Study	Date	Type Study	No. of Patients (Weeks' Gestation)	Findings
Tietze and Lewit[17,33]	1972 (D&E) 1973 (saline)	Multicenter, prospective, cohort, nonrandomized	N = 2734 2317 (13–14) 417 (15+)	Complication rates increase with increasing gestational age. Total complications for D&E fewer than saline at all gestations.
Stewart and Goldstein[34]	1972	Case series	N = 195 180 (13–14) 15 (15–16)	Complication rates increase with gestational age. No comparison of D&E and saline complications.
Brenner and Edelman[18] (includes data from US, England, India, and Singapore)	1974	Multicenter, prospective, cohort, nonrandomized	N = 338 (13–15)	Complication rates with sharp curettage through 15 weeks similar to saline at later gestations. Suction curettage alone had higher complication rates than sharp curettage alone.
Koplik[20]	1975	Case series	N = 141 95 (13–14) 46 (> 14)	No significant difference in complications by gestational age.
DeLee[35]	1976	Case series	N = 47 28 (14–16) 12 (17–19) 6 (20–22) 1 (23–24)	No major complications. One minor complication of fever.
Grimes, et al[20]	1977	Multicenter, prospective, cohort, nonrandomized	N = 6213 5632 (13–16) 581 (17–20)	Major complications for D&E 60% lower than for saline instillation.

Table 10-3 *(continued)*
Studies of Dilatation and Evacuation Procedures, United States

Study	Date	Type Study	No. of Patients (Weeks' Gestation)	Findings
Smith, Steinhoff and Palmore[10]	1978	Multicenter, prospective, cohort, nonrandomized	N = 721 696 (13–16) 25 (17–20)	Complication rates with D&E in 13 to 16-week range less than instillation procedures later.
Stubblefield, et al[11]	1978	Case series	N = 73 21 (13) 20 (14) 20 (15–16) 12 (17–18)	No major complications. Larger cannula had greater blood loss at lower gestational ages, but faster and more complete uterine evacuation.
Barr[14]	1978	Case series	N = 900 48.3% (18–20)	Major complication rate 0.44/100 D&E procedures. Two uterine perforations.
Glick and Sacks[27]	1978	Case series	N = 1074 334 (< 15) 289 (16) 267 (17–18) 156 (19–20) 23 (21–22) 5 (23–24)	Major complication rate 0.55/100 D&E procedures. Five cases of DIC, 1 recognized perforation.
Hanson[8]	1978	Case series	N = 3123 819 (14) 673 (15) 465 (16) 281 (17)	Major complication rate of 0.2%.

Study	Date	Type Study	No. of Patients (Weeks' Gestation)	Findings
Hanson[8] *(continued)*			332 (18) 246 (19) 200 (20) 21 (21)	
Berry and Peterson[32]	1978	Case series	N = >5000	Rate of uterine perforation < 0.4/100, transfusion < 0.1/100, infection 0.3/100.
Hodari, et al[30]	1977	Case series	N = 2490 1144 (15) 1012 (16) 267 (17) 57 (18) 7 (19) 3 (20)	Major complication rate of 1.65/100 D&E procedures. Total complication rate of 2.77/100 D&E procedures.
Hern and Oakes[9]	1977	Case series	N = 150 45 (13) 35 (14) 44 (15) 16 (16) 5 (17) 4 (18) 1 (19)	Mean blood loss 117 ml, mean operative time 10 minutes, one suspected uterine perforation, no major complications.
Goldsmith, Kaltreider, and Margolis[33]	1977	Case series	N = 130 24 (14–15) 59 (16–17) 36 (18–19) 11 (20)	Complication rates with D&E similar to those found in JPSA/CDC. Slightly higher rates for infection and retained tissue than JPSA/CDC.

Table 10-3 *(continued)*
Studies of Dilatation and Evacuation Procedures, United States

Study	Date	Type Study	No. of Patients (Weeks' Gestation)	Findings
Goodman[35]	1977	Case series	N = 50 17 (14–15) 22 (16–17) 11 (18–19)	No major complications. One case of febrile morbidity.
Livingston[5]	1977	Case series	N = 6168 5896 (13–14) 272 (15–16)	Major complication rate of 0.58/100 D&E procedures. Total complication rate of 7.4/100 D&E.
Burnhill[36]	1978	Case series	N = 568 207 (15) 348 (16) 6 (17) 6 (18) 1 (19)	Total complication rate of 10.2/100 D&E procedures. Perforations 14 times more frequent with D&E after 14 menstrual weeks than before. Series based on underestimated gestations.
Kaltreider, Goldsmith and Margolis[16]	1979	Cohort, nonrandomized	N = 250 52 (14–15) 106 (16–17) 72 (18–19) 20 (≥ 20)	D&E was associated with greater comfort and less guilt, anger, and depression than $PGF_2\alpha$.
Grimes, Hulka, and McCutchen[22]	In press	Randomized clinical trial	N = 94 8 (< 12) 16 (13–14) 34 (15–16) 27 (17–18) 6 (19–20) 3 (≥ 21)	Total complication rate 6/100 D&E procedures; 34/100 $PGF_2\alpha$ procedures. Significantly better compliance with D&E regimen, shorter hospital stay, fewer gastrointestinal side effects.

patients whose fetuses are judged to be of a gestational age greater than 12 weeks.

Predilatation by laminaria appears to have considerable support in the current practice of second-trimester D&E. Acute mechanical dilatation of the cervix to large diameters can be technically difficult, traumatic, and potentially deleterious to a woman's subsequent childbearing capacity.[6,7] Most physicians who use laminaria leave them in place from 8 to 12 hours to as long as 24 hours. An occasional physician uses laminaria for less than 12 hours for pregnancies ≤ 16 weeks,[8] while others use repetitive packings of multiple laminaria over 48 hours.[9]

Although local and general anesthesia are used for second-trimester D&E abortions, the former is more popular. While the risks of major complications associated with local or general anesthesia for first-trimester suction curettage are comparable,[10] several studies have documented significantly greater blood loss with general anesthesia.[11] This observation may be applicable to second-trimester D&E as well. Halothane and other agents which relax the uterus should be avoided.[12]

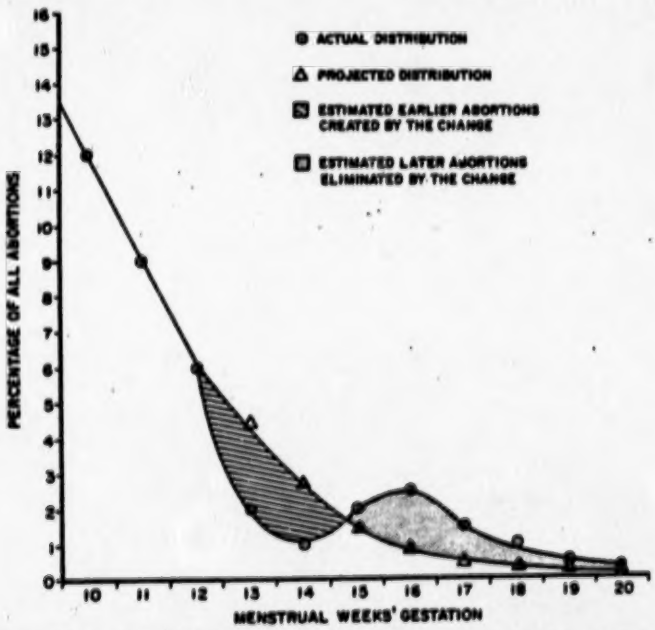

Figure 10-1 Actual distribution of abortions and projected distribution without any delay in the 13- to 16-week interval, by gestational age, US, 1975.

In addition to the smaller blood loss associated with local anesthesia, *intracervical* injection with anesthetics to which vasoconstrictors have been added may result in even less bleeding. As described by Finks, this procedure entails injecting a local anesthetic such as lidocaine with epinephrine deeply into the cervix and lower uterine segment.[13] Uptake of the solution in the uterus may be responsible for the effective hemostasis which is achieved in most cases. Extensive experience in the United States[14] as well as overseas[15,16] attests to the usefulness of this technique.

Most surgeons rely on large forceps to evacuate the products of conception. The commercially available Bierer, Sopher, Clemeston, or Peterson forceps feature heavy construction, long shanks, and reverse serrations on the grasping surfaces to provide a more secure grip. Large bore suction cannulae present an alternative to such forceps. Stubblefield and associates found that a 15.9 mm diameter suction cannula obviated the need for crushing forceps in the 15- to 16-week interval and earlier.[12] They also observed that the elimination of fetal dismemberment makes second-trimester D&E more acceptable to physicians. For later pregnancies, forceps were required, however.

Administration of oxytocic agents and prophylactic antibiotics varies from institution to institution. Many physicians give oxytocics to decrease intraoperative bleeding and to provide a firmer uterine wall. Others avoid them in hopes of avoiding entrapment of the fetal calvarium. Prophylactic antibiotics, usually tetracycline or doxycycline, commonly are given postoperatively.

Morbidity and Mortality

Dilatation and evacuation appears to be the safest available method of abortion through 20 weeks' gestation. As summarized in Table 10-3, numerous case series have documented major complication rates ranging from 0.4 to 1.7 per 100 abortions. Total complication rates have varied from 2.8 to 10.2 per 100 abortions.

Comparative studies are more illuminating, however. For example, Kaltreider, Goldsmith, and Margolis focused on the psychologic morbidity of D&E compared to intraamniotic $PGF_2\alpha$.[18] They found that D&E was associated with greater patient comfort and less guilt, anger, and depression than instillation of $PGF_2\alpha$. They also noted that much of the emotional burden of the abortion was shifted from the woman to the physician in these cases.

The initial report of the Joint Program for the Study of Abortion demonstrated that the major complication rate for D&E at 13 to 14 weeks' gestation (0.8 per 100 abortions) was less than that for saline instillation at any gestational age (1.4 to 2.5 per 100 abortions).[17] In

addition, the total complication rate for D&E at ≥ 15 weeks' gestation (7.9 per 100 abortions) was less than that for saline instillation at any gestational age (21.0 to 29.5 per 100 abortions).

Brenner and Edelman observed that performing a D&E abortion in the 13- to 15-week interval may be preferable to delaying until the woman is at ≥ 16 weeks' gestation for saline instillation.[18] The total complication rate associated with D&E at 13 to 15 weeks' gestation was 12.5 per 100 abortions, while that observed with saline instillation at 16 to 18 weeks was 10.6. However, "the saline method appeared to be associated with higher rates of serious or potentially serious complications—infections, pulmonary complications and death."[18]

Examining Hawaiian data, Smith and associates reached similar conclusions.[19] In the 13- to 16-week interval, D&E and suction curettage (alone or with sharp curettage) had total complication rates of 12.3 and 13.9 per 100 abortions, respectively. In contrast, saline abortion in this interval had a complication rate of 33.5. Smith et al. concluded that instrumental evacuation was the method of choice in the 13- to 16-week interval; they further advised that waiting to perform amnioinfusion was not justifiable in an attempt to reduce medical risks.

The second phase of the Joint Program for the Study of Abortion, incorporating an even larger sample size, corroborated the earlier findings.[20] In a comparison of 6213 abortions by D&E and 8662 by saline instillation at 13 to 20 weeks' gestation, D&E was found to be significantly safer. Major complication rates associated with the two methods were 0.69 and 1.78 per 100 abortions, respectively. Total complication rates paralleled major complication rates, although the differences were even greater. Women receiving saline required treatments for their complications significantly more often.

Critics of such nonrandomized studies have challenged their findings and have called for a randomized clinical trial to resolve the question of safety.[21] In response, a study was conducted at the University of North Carolina of 100 patients estimated to be 13 to 18 weeks' pregnant.[22] Fifty were allocated randomly to abortion by outpatient D&E and 50 to instillation of $PGF_2\alpha$. There were no significant differences in the demographic characteristics of the patients in either subgroup.

Patients assigned to abortion by $PGF_2\alpha$ waited significantly longer to obtain an abortion. The total complication rate for D&E was 6 per 100 abortions, while that for $PGF_2\alpha$ was 34. No major complications occurred in the D&E group in contrast to three in the $PGF_2\alpha$-treated group.[22] In addition, all but two women assigned to D&E underwent abortion as outpatients, while all women receiving $PGF_2\alpha$ spent at least one night in the hospital.

The mortality statistics for second-trimester D&E confirm its safety relative to abortion by instillation of abortifacients (see Chapter 12). The risk of dying from a D&E abortion at ⩾ 13 weeks is greater than that from curettage abortion earlier in pregnancy; nevertheless, the risk of dying appears to be less than that from instillation of either saline or prostaglandin $F_2\alpha$. From 1972 to 1977, D&E had an overall death-to-case rate of 8.3 per 100,000 abortions, compared with 20.6 for instillation of prostaglandin $F_2\alpha$ (and other agents), and 15.5 for saline. Thus, in terms of both morbidity and mortality, D&E appears to be the safest available method of second-trimester abortion.

CLINICAL COMPARISON OF DILATATION AND EVACUATION WITH INSTILLATION ABORTION

The optimal method of second-trimester abortion should be simple, convenient, inexpensive, and safe. Although no current method for second-trimester abortion fulfills all of these criteria, D&E satisfies more of them than do present day alternatives.

Performing a second-trimester D&E is more complex technically than performing an amnioinfusion. However, this disadvantage is balanced by a significantly higher success rate than that generally obtained with instillation abortions,[20] and the dilemma of a live fetus is eliminated. Clearly, either failed abortion or delivery of a live fetus substantially complicates the abortion process for all concerned.

How technically difficult is a second-trimester D&E? The operation appears to be simpler than a vaginal hysterectomy, an operation all gynecologists have learned to perform. Nonetheless, appropriate training and equipment are prerequisites for safe performance of D&E abortions. Residents in obstetrics and gynecology at Harvard University, for example, learn to perform such procedures under faculty supervision.[13] It is questionable whether this educational activity is widespread.

From the physician's perspective, second-trimester D&E is not only more complex technically but emotionally as well. To perform an amnioinfusion and then to leave the woman in the care of nurses is simpler indeed than confronting the destruction of the fetus during a D&E abortion. Many activities in medicine are stressful to physicians. Overall concern should be focused primarily on the emotional burden of the woman requesting second-trimester abortion, and secondarily on that of the medical staff which cares for her. This statement notwithstanding, it is possible to design programs which attempt to address the concerns of the staff as well as of the patient.[16-23]

Second-trimester D&E is more convenient than abortion by instillation of abortifacients. The woman can be scheduled immediately

for surgery at a specific date and time rather than having to wait for a hospital bed to become available. Absences from work or school and arrangements for child care can be made with certainty. Delays are openly discouraged. Some clinics performing D&E abortions use a graduated fee scale which increases with advancing gestational age.[34] Women undergoing D&E as outpatients avoid the inconvenience of admission and discharge from a hospital as well.

The medical staff also may find D&E more convenient than instillation abortions. Physicians can schedule D&E procedures. In contrast, with instillation abortions, a physician must remain available to attend to problems during labor and to complete the abortion in a high percentage of cases.[20] Nursing care for a woman undergoing D&E abortion is abbreviated and more convenient as well.

A second-trimester D&E is less expensive than an instillation abortion. The principal reason is that D&E abortions usually are performed on an outpatient basis. Although this is not necessarily representative of fees throughout the United States in 1979, the Director of the National Abortion Federation reveals that instillation abortions may cost as much as $275 more than a second-trimester D&E abortion provided at the same facility.

Abortion by second-trimester D&E is generally faster than by instillation of abortifacients. Although intervals for cervical predilatation by laminaria vary, most authors report a surgical evacuation time of less than 20 minutes. Both with laminaria pretreatment[22] and without,[20] D&E has had a significantly shorter duration than instillation abortions. Repetitive packing of laminaria,[9] however, entails a longer interval for predilatation and, hence, a total time which may exceed the induction-to-abortion times obtained with current instillation regimens.

As noted previously, D&E appears to be the safest available method of second-trimester abortion. Case series, prospective single and multicenter cohort studies, a randomized clinical trial, and nationwide surveillance of abortion-related deaths, all support this conclusion. The potential late complications of second-trimester D&E, as well as of other second-trimester techniques, remain largely speculative. Clearly, additional study is needed in this area. Until such information is available, however, the choice of abortion methods should be based on currently known information rather than on speculation.

CONCLUSION

D&E is a leading method of second-trimester abortion in the United

States today in spite of allegations to the contrary.[11] The technique commonly consists of dilatation by laminaria followed by evacuation with special forceps, combined with sharp and suction curettage. More than 15 publications in the United States have documented low morbidity rates for the procedure, and nationwide surveillance of abortion deaths has demonstrated a low mortality rate as well.

Although D&E is technically and emotionally more complex for the physician, it is simpler, more convenient, less expensive, faster, and safer for the woman. It is emotionally less traumatic from the patient's point of view.[16] Existing data suggest that D&E should be considered against which all new methods of second-trimester abortion should be compared.

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Document #10

Abortion Facilities and the Risk of Death

By David A. Grimes, Willard Cates, Jr., and Richard M. Selik

Summary

While the number of abortions performed annually in the United States has increased steadily since 1969, the proportion of abortions performed in hospitals has been declining since 1975. Between 1974 and 1977, 1,229,000 abortions were performed at 12 or fewer weeks' gestation in U.S. hospitals, while 2,730,000 were performed in freestanding clinics and doctors' offices. Over the same period, there were 19 deaths which resulted from in-hospital procedures, and 17 from abortions performed in nonhospital facilities. The crude death-to-case rates are 1.5 deaths per 100,000 procedures for hospital abortions, and 0.6 deaths per 100,000 abortions performed in nonhospital facilities. When these rates are adjusted for the presence of preexisting medical conditions and for the concurrent performance of sterilizations, the death-to-case rates for first-trimester abortions performed in both kinds of facilities were about 0.7.

Survey Methodology

Abortion-related deaths were identified through the ongoing surveillance of abortion mortality by the Centers for Disease Control (CDC); the methods have been described previously.[1] We categorized by type of facility (hospital versus freestanding clinic or physician's office) all deaths associated with legal abortion at 12 or fewer weeks' gestation that occurred in the United States between January 1, 1974, and December 31, 1977. Since data supplied to the CDC do not include numbers of abortions by type of abortion facility, we obtained this information from the annual surveys of abortion providers conducted by The Alan Guttmacher Institute (AGI).[2] In these surveys, nonhospital facilities included freestanding abortion clinics, generally with large caseloads, and physicians who perform abortions in their offices. Abortions performed in hospitals or hospital clinics on an outpatient basis were categorized in the AGI surveys as hospital abortions.

For each kind of facility, we calculated death-to-case rates by dividing the number of deaths by the number of abortions performed between 1974 and 1977. The AGI surveys for 1976 and 1977 reported the number of abortions at 12 or fewer weeks' gestation performed in each type of facility.[3] To derive comparable denominators for the data from the 1974 and 1975 surveys, which did not report this breakdown, we assumed that all abortions at 13 or more weeks' gestation in 1974 and 1975 took place in hospitals. We then subtracted the estimated number of abortions at 13 or more weeks' gestation[4] from the AGI hospital abortion totals for 1974–1975. This provided an estimate of the number of abortions performed at 12 or fewer weeks' gestation in hospitals. We also assumed that all abortions in nonhospital facilities were at 12 or fewer weeks' gestation. We used the total number of abortions reported to the AGI for nonhospital facilities as the denominator for that category.

Results

Thirty-six women died as a result of legal abortions performed at 12 or fewer weeks' gestation in the United States during 1974–1977; 19 of the abortions were performed in hospitals, and 17, in nonhospital facilities. Characteristics of women in both groups were similar. The mean age of women who died after hospital abortions was 26.3 years; after nonhospital abortions, 23.5 years. Of the hospital group, 58 percent were white; of the nonhospital group, 53 percent. Mean gravidity for the hospital group was 2.8 pregnancies per woman, compared with 3.1 for the nonhospital group. Excluding the one nonhospital patient who was not pregnant at abortion, the mean gestational age of the hospital group was 9.8 weeks, compared with 9.2 weeks for the nonhospital group. None of these differences were statistically significant.

Eight women in the hospital group had preexisting medical problems, compared to only two in the nonhospital group. Seven in the hospital group underwent concurrent sterilization, while none in the nonhospital group did.

Table 1 shows the causes of death of all the 36 women. Adverse reactions to anesthesia or analgesia and embolic events were the commonest causes. No cause of death was represented disproportionately among the women in either group.

As Table 2 (page 32) shows, the 36 women who died were among 3,959,000* who underwent abortion at 12 or fewer weeks' gestation in the study period, for an overall death-to-case rate of 0.9 per 100,000 abortions. The crude death-to-case rate was 1.5 per 100,000 abortions for the hospital group and 0.6 for the nonhospital group.

Women who obtain abortions in hospitals and in nonhospital facilities are probably not comparable. Those receiving care in hospitals constitute a high-risk group because women who are ill or request concurrent sterilization are overrepresented among them. Accordingly, we have attempted to control for the distorting effects of preexist-

David A. Grimes is Assistant Chief and Willard Cates, Jr., is Chief of the Abortion Surveillance Branch, Family Planning Evaluation Division, at the Centers for Disease Control DHHS, Atlanta, Georgia. Richard M. Selik was an Epidemic Intelligence Service Officer in the Abortion Surveillance Branch. He is currently a Medical Epidemiologist with the Community Health Services Division of the New Jersey State Department of Health.

*This figure, which is also given in Table 2, differs slightly from the total number of first-trimester abortions reported in the AGI annual surveys for 1974–1977 (see reference 3). The discrepancy occurs because the numbers of first-trimester abortions performed in hospitals and in clinics were not directly available from the 1974 and 1975 AGI surveys. For those two years, the figures were estimated, using CDC data for the proportion of all abortions which took place in the first trimester (see reference 4). This proportion was applied to the AGI total of hospital abortions to yield the number taking place in the first trimester. It was assumed that all nonhospital abortions took place in the first trimester. Although the total differs slightly from that reported to AGI, the difference is small, and does not affect the death-to-case rates reported here.

ing health problems and concurrent sterilization on the risk of death among the hospital group. Based on the distribution in the Joint Program for the Study of Abortion (conducted under the auspices of the CDC), we assumed that 15.9 percent of women undergoing abortion at 12 or fewer weeks' gestation had one or more preexisting medical problems.[5] We subtracted this proportion of women from the denominator and the eight cases with preexisting problems from the numerator. This adjustment lowered the death-to-case rate for the hospital group to 1.1 deaths per 100,000 abortions.

Similarly, we assumed that 2.2 percent of women undergoing abortion at 12 or fewer weeks' gestation underwent concurrent sterilizations.[6] We subtracted this proportion of cases from the denominator of the hospital group and the seven cases involving sterilization from the numerator. This resulted in a death-to-case rate among the hospital group of 1.0 deaths per 100,000 abortions. Finally, we accounted for both factors simultaneously. We assumed that a maximum of 18.1 percent of women had a preexisting condition, underwent concurrent sterilization, or both, and we deleted this fraction from the hospital denominator. Similarly, we subtracted 12 cases involving either preexisting conditions or concurrent sterilization from the numerator. As the table shows, the resulting adjusted death-to-case rate for the hospital group is 0.7 deaths per 100,000 abortions, similar to the crude rate for the nonhospital group, 0.6 per 100,000.

Direct information about the number of deaths and number of abortions was available for 1976–1977 (although not for the earlier period). Among the 643,000 women who obtained hospital abortions in 1976–1977, six died, for a crude death-to-case rate of 0.9 deaths per 100,000 procedures. Similarly, five women out of 1,624,000 died after nonhospital abortions, for a crude death-to-case rate of 0.3. These rates derived from direct enumeration are consistent with our rates based upon the estimated denominators.

Discussion

This analysis suggests that the crude death-to-case rate is higher for abortions performed at 12 or fewer weeks' gestation in hospitals than it is for comparable abortions performed outside of hospitals. As shown in our previous study; however, adjusting for preexisting conditions and concurrent sterilization in the hospital group virtually eliminates the differences.[7] For several reasons, these death-to-case rates should be interpreted cautiously. First, the number of deaths in each group is small. In such a situation, small changes in the number of deaths produce large fluctuations in death-to-case rates. Underreporting of deaths may also bias these rates. However, the CDC's active surveillance system identifies 50 percent more abortion-related deaths than are detected through traditional vital statistics channels, and systematic underreporting of deaths following abortion in either type of facility is unlikely.[8]

A second important limitation of these rates concerns the fact that their denominators are estimates. Data on the number of abortions at 12 or fewer weeks' gestation by type of facility were only available for 1976 and 1977; the numbers for 1974–1975 were estimated. To the extent that abortions at 13 or more weeks' gestation were performed in nonhospital facilities in 1974–1975, our estimated number of abortions at 12 or fewer weeks' gestation in hospitals is too low, and the death-to-case rate, therefore, too high. Similarly, to the extent that abortions at 13 or more weeks' gestation were performed in nonhospital facilities in 1974–1975, the estimated number of abortions at 12 or fewer weeks' gestation in nonhospital facilities is too high and the death-to-case rate too low. Thus, if our initial assumptions about the gestational-age distributions for abortions in each type of facility in 1974–1975 were inaccurate, they would tend to make hospital abortions appear less safe.

Data from 1976 and 1977 suggest that in 1974–1975, abortions at 13 or more weeks' gestation were *not*, in fact, limited to hospi-

Table 1. Weeks since last menstrual period (LMP), preexisting health conditions, performance of concurrent sterilization and causes of death for women who died following legal abortion at 12 or fewer weeks' gestation, by type of facility, United States, 1974–1977

Weeks since LMP	Preexisting conditions	Concurrent sterilization	Cause of death
Hospital			
6	None	No	Reaction to anesthesia
8	None	Laparoscopy	Cerebral hypoxia
8	Hodgkin's disease	No	Pulmonary embolus
8	None	Laparotomy	Pulmonary embolus
8	None	No	Suspected pulmonary embolus
9	None	No	Reaction to anesthesia
9	Rheumatoid arthritis	No	Myocarditis
10	None	Laparotomy	Pulmonary embolus
10	None	No	Myocarditis
10	None	No	Reaction to anesthesia
10	Heart disease	Hysterectomy	Heart disease
10	None	Laparotomy	Reaction to anesthesia
11	None	No	Hemorrhage
11	Heart disease	Laparotomy	Suspected cerebral embolus
11	Obesity, hypertension	Laparotomy	Reaction to anesthesia
12	Heart disease	No	Heart disease
12	None	No	Sepsis
12	Thrombophlebitis	No	Pulmonary embolus
12	Obesity	No	Hemorrhage
Nonhospital			
Not pregnant	None	No	Reaction to anesthesia
4	None	No	Reaction to anesthesia
5	None	No	Sepsis
6	None	No	Cerebrovascular accident
8	None	No	Reaction to anesthesia
9	None	No	Peritonitis
9	None	No	Pulmonary embolus
9	None	No	Hemorrhage
9	None	No	Hemorrhage
10	None	No	Reaction to anesthesia
10	None	No	Air embolus
10	Coronary artery disease	No	Suspected myocardial infarction
11	None	No	Pulmonary embolus
11	None	No	Sepsis
12	Drug addiction	No	Reaction to analgesia
12	None	No	Reaction to anesthesia
12	None	No	Hemorrhage

Table 2. Number of deaths, number of abortions and death-to-case rates for abortions at 12 or fewer weeks' gestation by type of facility, including and excluding women with preexisting medical conditions and concurrent sterilizations, United States, 1974–1977

Type of facility	No. of deaths	No. of abortions	Death-to-case rate*
Including women with medical conditions or sterilization			
Total	36	3,959,000	0.9
Hospital	19	1,229,000	1.5
Nonhospital	17	2,730,000	0.6
Excluding women with medical conditions or sterilization			
Total	24	3,737,000	0.6
Hospital	7	1,007,000	0.7
Nonhospital	15	2,296,000	0.7

*Deaths per 100,000 abortions.

tals. In 1976, 24 percent of all abortions at 13 or more weeks' gestation were performed in nonhospital facilities, and this percentage increased to 33 percent in 1977.[9] To measure the potential influence of our assumptions about denominators on the results, we applied the 1976 distribution of abortions at 13 or more weeks' gestation to the 1974–1975 totals for each type of facility. Using these revised denominators for 1974–1975, we recalculated the death-to-case rates for 1974–1977. The crude rates for hospitals and nonhospital facilities were unchanged. Adjusted for preexisting conditions, the death-to-case rate for the hospital group fell to 1.0 deaths per 100,000 abortions; adjusted for sterilization, it was also 1.0; adjusted for both factors simultaneously, it was 0.7. Thus, any imprecision in our denominator estimates had a negligible impact on the results.

While concurrent sterilization is usually limited to women having an abortion in a hospital, preexisting medical problems are found among patients in both groups. To assess the risk of death in nonhospital facilities for women without preexisting problems, we adjusted the nonhospital death-to-case rate, again assuming a 15.9 percent prevalence of preexisting conditions. Subtracting two deaths from the numerator and about 400,000 abortions from the denominator increased the death-to-case rate from 0.6 to 0.7 deaths per 100,000 for nonhospital abortions as Table 2 shows. This rate is equivalent to the adjusted rate for the hospital group.

Although perforation of the uterus probably lingers as the most feared complication of abortion at 12 or fewer weeks' gestation, anesthesia and analgesia accidents have, in fact, claimed more lives. In the period 1974–1977, complications of anesthesia or analgesia were the most frequent cause of death, concurrently are likely to receive these services in hospitals, women coming to accounting for nearly one-third of all deaths, as Table 1 shows. Deficiencies in technique, equipment or personnel were not unique to either hospital or nonhospital facilities. Whenever drugs are administered for sedation or pain relief, comprehensive resuscitation equipment as well as staff experienced in its use must be available immediately.[10]

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Christopher Tietze

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Complications and Sequelae

Induced abortion, at any period of gestation, exposes a woman to a risk of complications that is always larger than zero but that can vary considerably, depending on the circumstances under which the abortion is performed. The severity of complications also varies widely from very minor complaints to the occasional fatal outcome. Complications can be divided into two categories—early, that is, within around one month after the abortion, and late, those occurring more than one month after the procedure. Early complications may be further subdivided into immediate, defined as those occurring (although not necessarily discovered) during the procedure or within a few hours after its completion, and delayed complications, those developing later but still within one month.

Serious immediate complications are rare with abortions performed in medical settings. They include perforation of the uterus by one of the instruments used for instrumental evacuation, sometimes combined with injury to the intestines or other organs; major hemorrhage; laceration of the cervix; severe disturbances of blood coagulation and hypernatremia associated with saline-induced abortions; water intoxication resulting from the use of high doses of oxytocin; and untoward effects of general or local anesthesia.

The most frequent delayed complications include retention of fragments of the placenta resulting in postabortal bleeding; infection, which may range from mild endometritis through more severe forms of pelvic inflammatory disease to generalized peritonitis and septicemia; and venous thrombophlebitis resulting in pulmonary embolism. Postabortal depression has been reported but is rare, and guilt feelings are usually of short duration (*Brewer, 1977; David, 1978b*). The psychological reaction most commonly noted is relief.

Known late somatic complications or sequelae of induced abortions in medical settings are sensitization of Rh-negative women by red blood cells from an Rh-positive fetus, preventable by injection of Rh-immune globulin, and endometriosis in scar tissue after hysterotomy. Over the past decade, several investigators have addressed themselves to the question of possible adverse outcome of pregnancies following induced abortion, primarily low birth weight, short gestation, and second trimester spontaneous abortion. Major problems encountered in these studies include the following:

1 Many women are reluctant to reveal prior induced abortions, even those obtained in legal settings. Because they may be more willing to do so if the outcome of a subsequent pregnancy has been unfavorable (*Hogue, 1975*) or such an event is threatened, it is important that the prior abortion experience be ascertained before an adverse outcome of the subsequent pregnancy is known or suspected.
2 Low birth weight, short gestation, and spontaneous abortion are associated with a variety of background factors, including the woman's age, parity, ethnicity, socioeconomic status, and smoking habits, that may be independently associated with the incidence of induced abortion. Some investigators have not taken these factors into consideration, while attempts at more complete analysis have been constrained by loss of statistical significance.

Because risks to the outcome of subsequent pregnancies are of greatest interest to women who terminate their first pregnancy or pregnancies by induced abortion but may want children later, Table 19 presents a synopsis of nine major studies of the outcome of the first pregnancy following one or more abortions performed in medical settings. These studies were conducted in 16 locations and involved a total of about 12,000 women with abortion experience and 90,000 women in comparison groups.[1] The number of study groups (SGs), defined in terms of location, adverse outcome, and method of abortion, is 29, including two with information on women who had two or more abortions prior to the pregnancy under consideration.

1 When women with one abortion and no other prior pregnancies are compared with women pregnant for the first time (gravida 1), they have a relative risk of adverse outcome greater than unity in only 12 of the 29 SGs.
2 The relative risk is significantly increased (at the 0.05 level) in only two SGs. However, of the 27 SGs with statistically nonsignificant findings, only 13 are large enough to offer at least an 80 percent chance of detecting a risk of adverse outcome twice as large as in the comparison group.
3 The average relative risk (unweighted) is 1.08 for low birth weight, 1.05 for short gestation, and 1.45 for midtrimester spontaneous abortion. The average risk attributable to the abortion is quite small: 0.9 per 100 infants for low birth weight, virtually zero for short gestation, and 1.0 per 100 pregnancies for midtrimester spontaneous abortion.

[1] Excluding the earliest and largest of the nine studies (*Hungary, 1980*), there were 6,000 women with abortion experience and almost 33,000 women in comparison groups.

4 The two SGs with significantly increased risks of adverse outcomes involved surgical curettage in Hungary and Poland. It is not clear, however, whether the primary cause of the higher risk is the method of abortion or some other biological or social factor associated with geography. No consistent pattern was found in the locations where both methods were used.

5 When women with one prior abortion are compared with women pregnant for the second time following a live birth (gravida 2), the risks are almost always higher than when they are compared with primigravidae. A relative risk significantly greater than unity appears in 6 out of the 25 SGs for which this comparison is possible. This finding reflects the well-established higher risks normally associated with the first pregnancy. It can be argued that the induced abortion has merely shifted these higher risks from the first to the second pregnancy.

6 As one would expect, women who have had two or more induced abortions and no other prior pregnancy are subject to higher risks of adverse outcome in the first subsequent pregnancy than those who have had only one prior abortion. There is no indication, however, that the risks increase more than is explained by the multiple abortion experience. A sharply increased risk of spontaneous abortion after multiple induced abortions was also found in a study not included in Table 19 because it is not limited to first subsequent pregnancies (*Levin, 1980*).

Secondary sterility and ectopic pregnancy can be the late results of pelvic infection following self-induced abortions or abortions performed in nonmedical settings. The role of legal abortion in the etiology of these conditions and of placenta previa and dysmenorrhea has not been established. Sterility can also result from hysterectomy, performed because of major hemorrhage in the course of another abortion procedure, but this is a rare occurrence in medical settings. In the Joint Program for the Study of Abortion (*Tietze, 1972*), 39 secondary hysterectomies were identified among 73,000 legal abortions in 1970/71, or one in 1,900 procedures. The incidence of these tragic events has doubtless declined with increasing experience. In Canada, only 24 secondary hysterectomies were reported among 238,000 abortions in 1974–79, or one in 10,000 cases (*Canada, 1980*).

Adverse psychological sequelae of induced abortion have been a matter of concern. Some authors, including some psychiatrists, have expressed the view that every abortion is a stressful experience involving major risks to mental health. Others have pointed out that most women undergoing abortion continue to lead essentially normal lives and that an adverse psychological reaction to an unwanted birth may be far more common and more serious than an adverse reaction to having an abortion. The WHO Scientific Group on Spontaneous and Induced Abortion concluded early on that "there is no doubt that the termination of pregnancy may precipitate a serious psychoneurotic or even psychotic reaction in a susceptible individual" (*WHO, 1970*, p. 41), but pointed out that emotional stress experienced by the woman may be more closely associated with such factors as the circumstances under which the abortion was performed (legal or clandestine), the period of gestation, the type of operation, and the attitudes of the woman's family and of the professionals and other persons involved in the abortion. This conclusion was reinforced by another Scientific Group, convened eight years later, which stated that "there is now a substantial body of data, reported from many countries after careful and objective follow-up, suggesting frequent psychological benefit and a low incidence of adverse psychological sequelae" (*WHO, 1978*, p. 22). With increasing acceptance of abortion by the medical profession and by the general public, concern about its long-term effects on mental health appears to be diminishing.

A quantitative comparison of morbidity resulting in different countries from, or associated with, legal abortion cannot be made at this time. Although the International Classification of Diseases adequately identifies many types of complications associated with termination of pregnancy, no standards exist for evaluating and recording the severity of these complications. It is, therefore, not surprising that the statistics on the early complications of legal abortions, published by national health authorities, are not comparable.

In 1978, complication rates officially reported from five countries ranged from 0.2 percent to 4.7 percent:

Country	Percent	
Czechoslovakia	0.2	
England and Wales	1.1	
1st trimester		0.7
2nd trimester		3.2
German Fed. Rep. (1979)	2.0	
1st trimester		1.7
2nd trimester		3.7
Canada	2.7	
1st trimester		1.0
2nd trimester		12.0
Denmark	4.7	
1st trimester		4.6
2nd trimester		12.3

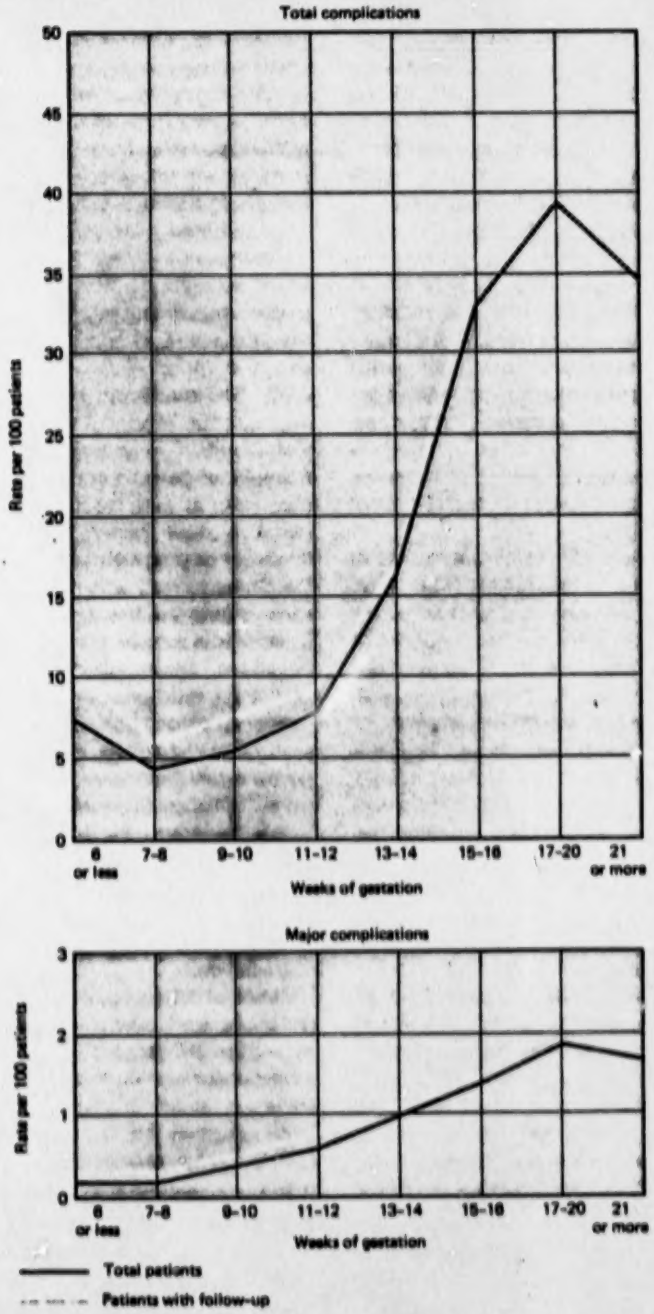
The rates for England and Wales are based on the number of complications reported, those for the

other four countries on the number of women with one or more complications.

The most comprehensive large-scale investigations of early medical complications of legal abortions were undertaken in the United States by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council during 1970/71 (*Tietze, 1972, 1973b*) and continued by the Centers for Disease Control (CDC) as JPSA/CDC from 1971 to 1975. These two large-scale studies permit assessment of the interaction of variables that determine levels of morbidity, such as age and parity, socioeconomic and health status, period of gestation, operative procedure, concurrent sterilization, and other factors.

Rates of "total" and "major" complications obtained by JPSA/CDC are shown in Table 20 and Figure 12. The rates of total complications are very high because the case records submitted by the participating institutions included many minor complaints, such as a single day of fever or vomiting after anesthesia, that are not usually listed in official reports. A broad definition of complications has the advantage of including complaints reported by patients as well as diagnoses by physicians and of permitting the analysis of incidence for comparatively small numbers of women. However, it may produce a distorted impression of the risk to health associated with legal abortion. A more restricted group of major complications was, therefore, identified in the JPSA/CDC, including the following: cardiac arrest; convulsions; endotoxic shock; fever for three or more days; hemorrhage necessitating blood transfusion; hypernatremia; injury to bladder, ureter, or intestines; pelvic infection with two or more days of fever and a peak of at least 40° C or with

FIGURE 12 Range of complication rates per 100 abortion patients without preexisting complications or concurrent sterilization, by weeks of gestation: United States, 1971–75 (JPSA/CDC)



hospitalization for 11 or more days; pulmonary embolism or infarction; thrombophlebitis; unintended major surgery; wound disruption after hysterotomy or hysterectomy; and of course death from any cause. (An almost identical classification was used in the original JPSA.) The total number of cases in the JPSA/CDC with one or more major complications was 6.5 percent of all patients with any complications.

Although every definition of a major complication is arbitrary to some degree, the proportion of such complications, as defined above, among each type of complication corresponded to the judgment of experienced clinicians. Furthermore, the patterns of major and total complications were similar in their association with such variables as period of gestation and operative procedure.

In analyzing the complications of abortion, a distinction should be drawn between complications associated with the termination of pregnancy and those associated with preexisting pathology or with surgical procedures undertaken for other purposes, such as the achievement of permanent sterility or the removal of the uterus because of fibroid tumors. For this reason, complication rates are shown not only for the aggregate of all patients but also for presumably healthy women subject to only the risks associated with the abortion procedure, that is, excluding all women with reported preexisting complications and those undergoing sterilizing operations.

Complication rates are also shown for total patients and for patients with follow-up. Follow-up was defined as any contact with the woman 14 or more days after the abortion, including contact by mail or by telephone either directly by the investigator or by the physician who referred her to the hospital or clinic or by the physician to whom she was referred for aftercare. The complication rate for total patients represents a minimum estimate of postabortal complications in the participating institutions. Since patients with complications are more likely to return for care than those without complications, the rate for patients with follow-up represents a maximum estimate of the incidence of postabortal complications.

As shown in Table 20, the minimum estimate of the total complication rate, including all reported diagnoses and complaints, was 12.3 per 100 for all women in JPSA/CDC. The maximum estimate was 14.9 per 100 women with follow-up. Complication rates were higher at 6 weeks of gestation or earlier than they were at 7–10 weeks, but complication rates during the second trimester of pregnancy were four to five times as high as corresponding rates during the first trimester. The pattern was similar for major complications, which are more significant than total complications. The incidence of total and of major complications increased by about 20 percent with *each week* of gestation from 7 through 20 weeks.

For total and major complications, the rates observed in the group of presumably healthy women, exposed to the risk of abortion only, were lower at each period of gestation.

Rates of total and of major complications were lowest for abortions by suction curettage at 12 weeks of gestation or earlier, followed in ascending order by instrumental evacuation at 13 weeks or later (D & E), intra-amniotic instillation of hypertonic saline solution, instillation of prostaglandin, hysterotomy, and hysterectomy.

The high rates of total complications for saline and prostaglandin instillation reflect a high incidence of retention of the placenta, requiring manual or instrumental removal, and, in the case of PG, of gastrointestinal symptoms, such as vomiting and diarrhea. Total and major complication rates for the two major surgical procedures are virtually identical. Complication rates for hysterotomy include abortions with concurrent sterilization because the two procedures are usually combined.

The differences in major complication rates between instrumental evacuation (D & E) and saline, as well as those between saline and PG, remain statistically significant (with p-values of less than .001 and .01, respectively) after standardization for woman's age, preexisting medical conditions, weeks of gestation, level of operator training, prophylactic use of antibiotics, and follow-up (*Grimes, 1977a, b, c*). The relative position of D & E vis-à-vis saline has also been confirmed by national mortality statistics in the United States and Britain and, most recently, by a controlled study (*Grimes, 1980*). These findings have important clinical and public health implications (*Cates, 1980a; Grimes, 1978*).

For women without preexisting complications who had abortions by suction, the risk of postabortal complications was considerably increased when abortion was combined with tubal sterilization via laparotomy, much less so when the tubes were approached by the laparoscopic route. The laparotomies were of the traditional type, with a comparatively large incision; minilaparotomy was not used in the participating institutions. Complication rates were virtually the same for women who had abortions under local and general anesthesia.

The following additional findings appear to be firmly supported by a

number of reports, including several controlled studies with random allocation of patients to different procedures and/or regimens, with excellent follow-up.

1 The incidence of early complications is lower with suction curettage than with surgical curettage (*Andolšek, 1974; Hungary, 1978*).

2 Loss of blood during suction curettage tends to be greater if the procedure is carried out under general anesthesia than if it is performed under local anesthesia (paracervical block). Although this difference was found to be statistically significant in at least one study, it was too small (about 10 ml) to be clinically significant (*Andolšek, 1977*). Perforation of the uterus, cervical injury, and hemorrhage were more often associated with general anesthesia; convulsions and postabortal pyrexia, with local anesthesia (*Grimes, 1979*).

3 The overall rate of delayed complications following suction curettage is about the same for women discharged from the outpatient service of a hospital three to five hours after the procedure and for women remaining overnight in the hospital (*Andolšek, 1977*).

4 The theoretical advantages of flexible over rigid cannulae have not been confirmed by controlled studies. Observed differences in complication rates are small and more often than not appear to favor the rigid models. Other characteristics of the cannula, such as number and site of holes, may be as important as flexibility (*Andolšek, 1976; Antonovski, 1975*).

5 Failure to terminate the pregnancy occurs more frequently with evacuation of the uterus during the first two weeks after a missed period, especially during the first week, than with suction curettage later in the first trimester (*GWUMC, 1974*).

6 The incidence of heavy uterine bleeding, requiring blood transfusion and/or surgical evacuation of the uterus, is higher following the intra-amniotic instillation of prostaglandin $F_{2\alpha}$ than of hypertonic saline solution (*WHO, 1976*). The statement in the WHO report that these differences were not statistically significant is incorrect (*Cates, 1978b*) and was subsequently amended by Bygdeman (*1978*).

7 The safety of immediate IUD insertion after abortion has been demonstrated by many investigators (*Andolšek, 1972; Burkman, 1977; Hue, 1974; Nygren, 1973; Ross, 1978; Solheim, 1976; Tatum, 1972; Timonen, 1974*).

8 According to one controlled study the combined frequency of abortion-related and sterilization-related complications was not significantly increased when the two procedures were done concurrently, compared with a six weeks delay of the sterilization (*Cheng, 1979*).

Successful performance of first-trimester abortions by midwives and other paramedical workers has been reported from several countries (*Faundes, 1972; Karman, 1972b; Rahman, 1980; Scotti, 1976*). Controlled studies comparing the incidence of complications for abortions performed by physicians with abortions performed by paraprofessionals have not been found in the literature.

TABLE 19 Synopsis of studies of adverse outcome of next pregnancies following one or more induced abortions, by type of outcome and method of abortion

Outcome and location of study	Design[1]	Meth. of ab.[2]	Ind. ab.'s[3]	Controlled variables[4]	COMPARISON WITH GRAVIDA 1 Attr. risk[5]	Rel. risk[6]	Stat. sign.[7]	COMPARISON WITH GRAVIDA 2 AFTER LIVE BIRTH Attr. risk[5]	Rel. risk[6]	Stat. sign.[7]
Adverse outcome: Low birth weight[8]										
Upstate New York[9]	HP	VA	1	A,C,E,M,R	2.7	1.45	NS+	3.5	1.67	S
Singapore[10]	HP	MVA	1	R	5.8	1.44	NS+	—	—	—
Hungary[11]	RC−	SC	1	None	3.4	1.33	SSS	5.3	1.65	SSS
Hungary[11]	RC−	SC	2+	None	7.1	1.70	SSS	9.1	2.11	SSS
Copenhagen, Newcastle[12]	RC+	VA	1	A,H,S	1.3	1.26	NS−	0.3	1.05	NS+
Helsinki, Ljubljana, Stockholm[12]	RC+	VA	1	A,H,S	0.9	1.22	NS−	1.9	1.57	NS−
Upstate New York[9]	HP	Sal	1	A,C,E,M,R	1.3	1.21	NS+	2.0	1.36	NS+
Debrecen, Lodz, Warsaw[12]	RC+	SC	1	A,H,S	1.3	1.16	NS+	3.4	1.56	S
Skopje[13]	HP	MVA	1	None	0.3	1.06	NS−	3.9	3.31	NS−
Hawaii[14]	HP	MVA	1	A,R,Y	−0.5	0.90	NS+	0.4	1.08	NS+
Seattle[15]	RC+	MVA	1	A,M,P,Re	−0.8	0.88	NS−	—	—	—
Upstate New York[9]	HP	SC	1	A,C,E,M,R	−0.9	0.85	NS+	0.4	1.08	NS+
Boston[16]	RC+	MVA	1	P,R	−1.4	0.83	NS+	1.0	1.17	NS+
Helsinki, Ljubljana, Stockholm[12]	RC+	SC	1	A,H,S	−1.2	0.51	NS−	−0.8	0.61	NS−
Adverse outcome: Short gestation[17]										
Helsinki, Ljubljana, Stockholm[12]	RC+	VA	1	A,G,S	2.7	1.94	NS−	3.6	2.80	SS
Upstate New York[9,18]	HP	Sal	1	A,C,E,M,R	1.1	1.53	NS−	1.8	2.20	S
Debrecen, Lodz, Warsaw[12]	RC+	SC	1	A,H,S	2.5	1.32	NS+	1.6	1.19	NS+
Copenhagen, Newcastle[12]	RC+	VA	1	A,G,S	0.0	1.00	NS−	0.8	1.21	NS−
Seattle[15]	RC+	MVA	1	A,M,P,Re	−0.5	0.95	NS+	—	—	—
Helsinki, Ljubljana, Stockholm[12]	RC+	SC	1	A,H,S	−0.2	0.91	NS−	0.3	1.20	NS−
Upstate New York[9,18]	HP	VA	1	A,C,E,M,R	−0.4	0.79	NS−	0.1	1.08	NS−
Upstate New York[19,18]	HP	SC	1	A,C,E,M,R	−0.5	0.76	NS+	0.2	1.14	NS−
Boston[16]	RC+	MVA	1	P,R	−1.9	0.72	NS+	0.0	1.00	NS−
Hawaii[14]	HP	MVA	1	A,R,Y	−2.9	0.57	NS+	1.7	1.38	NS+
Adverse outcome: Midtrimester abortion[19]										
Debrecen, Lodz, Warsaw[12]	RC+	SC	1	A,G,S	3.8	2.78	SSS	3.7	2.70	SSS
California[20]	RC+	MVA	1	A,G	1.8	1.81	NS+	—	—	—
California[20]	RC+	MVA	2+	A,G	4.6	3.13	SSS	—	—	—
Helsinki, Ljubljana, Stockholm[12]	RC+	SC	1	A,G,S	1.8	1.76	NS−	2.6	2.80	NS−
Copenhagen, Newcastle[12]	RC+	VA	1	A,G,S	−0.1	0.90	NS−	−0.3	0.77	NS−
Hawaii[21]	HP	MVA	1	A,C,R,Y	−0.9	0.72	NS−	−0.3	0.80	NS−
Helsinki, Ljubljana, Stockholm[12]	RC+	VA	1	A,G,S	−0.6	0.71	NS−	0.1	1.09	NS−

1. HP = Historical prospective; RC+ = Retrospective cohort, abortion experience ascertained before adverse outcome was known or suspected; RC− = Retrospective cohort, no information when abortion experience was ascertained.
2. Method of abortion: SC = Surgical curettage; VA = Vacuum aspiration (suction curettage); MVA = Mostly VA; Sal = Saline instillation.
3. Number of induced abortions preceding the index pregnancy (2+ = 2 or more); no other prior pregnancy.
4. A = Age of mother; C = County of residence; E = Education; G = Gestation at booking; H = Height of mother; M = Marital status; P = Payment status; R = Race or ethnicity; Re = Religion; S = Smoking habit during pregnancy; Y = Year of outcome.
5. Attributable risk = Difference in frequency of adverse outcome between women with abortion experience and comparison group, expressed in percent of births or pregnancies at risk.
6. Relative risk = Frequency of adverse outcome in women with abortion experience divided by frequency in comparison group.
7. Statistical significance: S = Significant at the 0.05 level; the probability that a difference as great as or greater than found would occur as a result of random variation is one in twenty. SS = Significant at the 0.01 level. SSS = Significant at the 0.001 level. NS+ = Not significant; the probability that a difference as great as or greater than found is greater than one in twenty and the number of cases is large enough to offer at least an 80 percent chance of detecting a doubled risk. NS− = The chance of detecting a doubled risk is less than 80 percent. These probabilities were computed by W. Cates, Jr. of the Centers for Disease Control. His help is gratefully acknowledged.
8. Generally live infants weighing less than 2,500 (or 2,501) gram. Rates per 100 births.
9. *Logrillo, 1980.*
10. *Hogue, 1979, 1980.*
11. *Hungary, 1980.*
12. *World Health Organization, 1979.*
13. *Hogue, 1975.* Method: 64 percent suction curettage, 24 percent surgical curettage, 12 percent other.
14. *Chung, 1980a.*
15. *Daling, 1977.*
16. *Schoenbaum, 1980.*
17. Generally live infants born less than 37 weeks from onset of last menstrual period. Rates per 100 births.
18. Less than 33 weeks from LMP.
19. Rates per 100 pregnancies at risk.
20. *Harlap, 1979.*
21. *Chung, 1980b.*

TABLE 20 Total and major complications per 100 women, by gestation, procedure, sterilization, and anesthesia, for total patients and for patients with follow-up (FU): United States, 1971/75

Gestation (weeks), procedure, sterilization, and anesthesia	TOTAL COMPLICATIONS		MAJOR COMPLICATIONS	
	Total patients	Patients with FU	Total patients	Patients with FU
All patients				
6 or less	7.2	10.3	0.4	0.6
7-8	4.7	6.6	0.3	0.4
9-10	5.6	7.7	0.4	0.6
11-12	8.2	9.9	0.8	1.0
13-14	17.0	18.1	1.4	1.6
15-16	33.1	36.2	1.9	2.1
17-20	39.9	47.4	2.2	2.5
21 or more	36.1	47.5	2.3	2.9
12 or less	6.0	8.1	0.4	0.6
13 or more	31.3	35.5	1.9	2.2
All gestations	12.3	14.9	0.8	1.0
Patients without preexisting complications or concurrent sterilization				
6 or less	7.2	10.3	0.2	0.3
7-8	4.4	6.1	0.2	0.3
9-10	5.3	7.3	0.4	0.5
11-12	7.7	9.1	0.6	0.8
13-14	16.4	17.0	1.0	1.1
15-16	33.1	35.7	1.4	1.5
17-20	39.7	46.7	1.9	2.3
21 or more	34.6	45.2	1.7	2.2
12 or less	5.7	7.6	0.4	0.5
13 or more	31.0	34.6	1.5	1.7
All gestations	21.1	14.5	0.7	0.8
Procedure[1]				
Suction curettage[2,3]	4.7	6.5	0.3	0.4
D & E[3,4]	5.5	6.7	0.6	0.6
Saline[3,5]	38.0	47.0	1.7	2.1
Prostaglandin[3,5]	53.1	54.5	2.8	2.6
Hysterotomy[6]	47.0	48.1	13.9	15.2
Hysterectomy	49.5	48.8	13.4	13.4
Suction curettage[1,3]				
6 or less	6.0	9.2	0.2	0.3
7-8	4.0	5.7	0.2	0.3
9-10	4.7	6.6	0.3	0.4
11-12	5.2	6.5	0.4	0.6
D & E[1,3,4]				
13-16	5.6	6.8	0.6	0.7
17 or more	4.8	5.3	0.5	0.5
Saline[1,3,5]				
13-16	42.1	50.9	1.7	1.7
17 or more	36.3	45.4	1.7	2.2
Prostaglandin[1,3,5]				
13-16	55.0	55.5	2.8	2.1
17 or more	51.9	53.9	2.8	3.0
Tubal sterilization[1,2,7]				
Not done	4.7	6.5	0.3	0.4
By laparotomy	22.6	24.5	3.2	3.1
By laparoscopy	7.6	8.5	0.8	1.2
Anesthesia[1,2,3,7]				
Local	4.2	6.0	0.3	0.4
General	5.6	7.5	0.3	0.5

1. Without preexisting complications.
2. At 12 weeks of gestation or earlier.
3. Without tubal sterilization.
4. Instrumental evacuation at 13 weeks of gestation or later.
5. Intra-amniotic instillation.
6. With tubal sterilization.
7. Aborted by suction curettage.

SOURCE: *United States, 1978.*

Document #12

Late Effects of Induced Abortion
Hypothesis or Knowledge?

Willard Cates, Jr., M.D., M.P.H.

Recent local, state and federal regulations intending to provide "informed consent" for women considering termination of pregnancy have misrepresented the current state of knowledge about certain long-term complications: the alleged risks are presented to the patient as if they were scientific facts rather than still-unproven hypotheses. While it is possible that some late sequelae are associated with previously induced abortions, there is no agreement in the scientific literature on the magnitude of the risks, if any. Moreover, few studies adequately define the particular method of induced abortion whose effects they are investigating. The current data do not support firm conclusions about induced abortion either causing or not causing any of the alleged long-term complications.

From the Abortion Surveillance Branch, Family Planning Evaluation Division, Center for Disease Control, Atlanta, Georgia.

Address reprint requests to: Willard Cates, Jr., M.D., M.P.H., Chief, Abortion Surveillance Branch, Center for Disease Control, Atlanta, Georgia 30333.

Recent legislation has been introduced at local, state and national levels to regulate the content of information provided to women requesting abortion services.[7] The primary purpose of this legislation is to provide more comprehensive "informed consent" for women considering termination of pregnancy. However, many regulations do not objectively represent the current state of knowledge about certain long-term complications; the alleged risks are presented to the patient as if they were scientific conclusions rather than still-unproven hypotheses. For example, one regulation requires that the woman be told that abortion produces "sterility, increase in the incidence of premature births, tubal pregnancies, and stillbirths in subsequent pregnancies."[8]

While it is possible that some of these complications are associated with previously induced abortions, there is no agreement in the scientific literature on the magnitude of the risks, if any. Moreover, few studies adequately define the particular method of induced abortion whose effects they are investigating. In this brief article, I will describe the design complexities of the different studies on the long-term effects of induced abortion and summarize the findings of the published analytic studies dealing with such alleged complications as sterility, ectopic pregnancy, spontaneous abortion, prematurity, pregnancy complications and birth defects.

Variation in the Abortion Procedure

The term *induced abortion* is used generically to describe many different procedures (Table I). The most obvious variable potentially affecting long-term complications from induced abortion is whether it was performed under legal or illegal conditions. Clandestine procedures are presumably more risky than those performed by qualified physicians in hospital or clinic settings; yet, many of the published studies were conducted in countries where induced abortion has not been legalized, such as Greece, Israel and Taiwan. Thus, the inferences drawn from these studies cannot be generalized to the United States, where, on the whole, safe, legal abortion is available at the request of the woman.

Other variables also affect long-term complications from induced abortion. Factors not directly related to the abortion procedure itself influence its outcome (Table I). Such variables as the patient's demographic profile, medical risk factors, the fa-

cility in which the procedure is performed, the use of prophylactic antibiotics and the type of postabortion contraception may independently influence the incidence and/or spectrum of postabortion morbidity. Other factors related to the technical aspects of the procedure may also affect the complication rate. Such variables as type of anesthesia, method of dilatation, amount of dilatation, type of instrumentation and length of operative procedure have been shown to affect short-term abortion morbidity and thus potentially influence the long-term sequelae. Finally, any woman undergoing a concurrent sterilization procedure with her abortion will obviously be at reduced risk of suf-

Table I *Some Variables Potentially Affecting Long-Term Complications from Induced Abortions*

Category	Variable
Legal status of induced abortion	Legal
	Illegal—physician-induced
	Illegal—nonphysician induced
	Illegal—self-induced
Patient's demographic profile	Age
	Race
	Gravidity
	Parity
	Socioeconomic status
Patient's medical risk factors	Preexisting conditions
	Gestational age
	Position of the uterus
	Number of previous induced abortions
	Number of previous spontaneous abortions
Operator's skill	Level of training
	Previous abortion experience
	Innate ability
Type of anesthesia	None
	Local
	General
	Regional
	Combination
Type of dilatation	None
	Metal
	Plastic
	Laminaria—single
	Laminaria—multiple
	Chemical
	Vibrator
Amount of dilatation	As recorded in millimeters
Type of instrumentation	Uterine sound
	Flexible suction curette
	Rigid suction curette
	Sharp curette
	Ring forceps
	Intrauterine catheter
	Combination
	Postevacuation sharp curette
Size of instrumentation	As recorded in millimeters
Length of operative procedure	As recorded in minutes or hours

Table I *(continued)*

Category	Variable
Type of abortifacient	Saline Prostaglandin Urea Oxytocin Combination
Type of facility and/or service	Hospital inpatient Hospital outpatient Type of hospital Free-standing clinic Physician's office
Use of prophylactic antibiotics	No Yes Type of antibiotic
Concurrent sterilization	Laparoscopic cauterization Laparoscopic clip Minilaparotomy with ligation Abdominal laparotomy with ligation Vaginal approach with ligation Hysterectomy
Postabortion contraception	None IUD inserted after uterine evacuation Oral contraceptives initiated Barrier methods
Short-term complications	Pelvic infection Cervical rupture/laceration Uterine rupture Uterine perforation Uterine synechiae Rh sensitization

fering any future pregnancy-related morbidity.

Because of the many technical factors having a possible effect on the long-term complications of induced abortion, studies which focus on aggregated abortion procedures should be viewed with caution. The recent multicenter World Health Organization study has found that the use of larger-caliber dilatation and sharp curettage increases the likelihood of spontaneous abortion, prematurity and low-birth-weight infants in future pregnancies.[13] However, suction curettage was generally associated with a lower increased risk in some countries and no increased risk in others. In the United States, nearly 96% of all abortions performed at 12 weeks are by suction rather than sharp curettage.[3] Therefore, future studies must carefully define the particular abortion procedure whose influence on long-term complications is being evaluated. Without adequate specification of the abortion procedures used, the aggregated data from all "induced abortions" may be misleading.

Differences in Research Design and Analysis

Different research approaches have been used to determine whether induced abortion has any long-term sequelae. Some studies are well designed and permit valid inferences, while others have a weaker scientific foundation and are at best suggestive. Moreover, even the most careful investigation may suffer from one of several potential biases which could affect its results.

Many studies are simply descriptions of the previous abortion histories of women who experience one of the possible long-term complications, referred to as case-series reports; no control populations are provided. Without appropriate comparison groups, the value of these uncontrolled observations is questionable. For example, documenting the prevalence of prior induced abortion in women who have subsequent ectopic pregnancies provides no information on what the baseline prevalence of induced abortion is in the population being studied.[11]

Table II *Sources of Potential Bias in Studies on Long-Term Effects of Induced Abortion*

Source	Definition	Example
Selection bias	Differences in selecting the study population and controls	Use of selected registry to identify previous aborters but not controls
Information bias	Differences between the study population and controls in ascertaining a history of previous abortion	Nonadmission of previous abortion, "biased" recall if adverse outcome occurs
Confounding	Differences between the study population and controls in the distribution of variable(s) associated with both induced abortion and adverse sequelae	Age, birth order, pregnancy order, smoking, socioeconomic status, etc.
Chance	Probability that an observed association may be due to chance	Too small a study population to allow achievement of statistical significance, inappropriate method of statistical analysis

Other investigations within various countries have analyzed the secular trends in complications before and after legal abortion was available. Although this approach may find a temporal association between the availability of legal abortion and a particular outcome, it does not permit causal inferences to be drawn. For example, if induced abortion is found to be temporally associated with adverse outcomes, other confounding factors may be more directly involved. As evidence, in England the increasing incidence of ectopic pregnancy was found to be more strongly related to an increased rate of pelvic inflammatory disease rather than to the increasing number of induced abortions.[1]

Analytic studies are those which provide comparison groups. However, even with analytic studies, at least four sources of bias can occur which affect the results (Table II): (1) *Selection bias* refers to differences used in selecting the study population and the controls; for example, if a selected registry, such as women attending an infertility clinic, is used to identify previous aborters but controls are chosen from women seen in a prenatal clinic, selection bias might occur. (2) *Information bias* involves differences in ascertaining a previous abortion history between the study population and controls; for example, women who suffer adverse outcomes might be more likely to "recall" a prior induced abortion to explain their subsequent problem than women who have normal outcomes. (3) *Confounding* can occur if there are differences between the study population and controls in the distribution of variables associated with *both* induced abortion and the long-term complications. Such variables as age, birth order, pregnancy order, smoking, socioeconomic status and history of spontaneous abortion all have been shown to be related to women seeking induced abortions as well as to other pregnancy-related morbidity. (4) *Chance* must be ruled out as an explanation for either an observed association or an observed nonassociation. For example, selection of too small a study population to allow achievement of statistical significance would lead to errors in concluding that there is no association when in fact there really is. Alternatively, inappropriate use of statistical methods can lead to finding an association which might not be real.

Because of these differences in research design and the possibility of sources of bias, no single study should form the basis for establishing a causal relationship. Rather, each study should be considered separately for its strengths and weaknesses. Those with serious design deficiencies should not be given much weight. Those with the best study design should be viewed *in toto* to see if their results support each other. The more consistent the findings among the best-quality studies, the more likely that a causal factor exists.

Summary of Available Literature

The available analytic case-control and cohort studies generally form no consistent pattern (Table III). The two published investigations from the United States have found no effect of induced abortion on any of the subsequent adverse out-

Table III *Summary of Results of Case-Control and Cohort Studies on Outcome of Pregnancy After Induced Abortion*

Study	Country	Years of study	Status of abortion	Effects*					
				Sterility	Ectopic pregnancy	Spontaneous abortion	Low birth weight/ prematurity	Complications of pregnancy	Birth defects
Daling (1977)	USA	1972-74	Legal	--	No	No	No	--	No
Kline (1978)	USA	1974-76	Legal	--	--	No	--	--	--
Schoenbaum (1977)†	USA	1975-76	Legal	--	--	--	No	No	No
Chung (1977)†	USA	1970-74	Legal	--	No	Yes[a]	No	No	No
Bracken (1978)†	USA	1974-76	Legal	--	--	--	--	--	No
Levin (1978)†	USA	1976-78	Legal	--	--	2.7[b]	--	--	--
Logrillo (1978)†	USA	1970-76	Legal	--	--	1.9	1.7	Yes[c]	No
Daling (1975)	Taiwan	1965-68	Illegal	--	--	No	No	--	--
Roht (1973, 1976)	Japan	1971	Legal	No	No	Yes[d]	Yes[e]	--	--
Hayashi (1966)	Japan	1961-62	Legal	No	--	--	--	--	--
Moriyama (1966)	Japan	1961-62	Legal	--	--	1.6	1.4	--	--
Furusawa (1966)	Japan	1952-64	Legal	--	--	--	--	No	--
Sawazaki (1966)	Japan	1959-64	Legal	--	No	--	--	--	--
Trichopoulos (1976)	Greece	1973-74	Illegal	3.4	--	--	--	--	--
Panayotou (1972)	Greece	1970-71	Illegal	--	2.4	--	--	--	--
Papavangelou (1973)	Greece	1969-70	Illegal	--	--	--	2.1	--	--
Pantelakis (1973)	Greece	1966-68	Illegal	--	--	--	2.1	--	--
Harlap (1975)	Israel	1966-68	Illegal	--	--	--	1.3	Yes[f]	1.3
Wright (1972)	England	1971	Legal	--	--	9.4	No	--	--
Liu (1972)	England	1971-72	Legal	--	--	6.3	--	--	--
Richardson (1976)	England	Not given	Legal	--	--	6.3	2.5	--	--
Lembrych (1972)	Poland	1966-68	Legal	--	--	--	2.6	Yes[f]	--
Dziewulska (1973)	Poland	Not given	Legal	--	2.7	2.1	2.3	Yes[g]	--
Drac (1970)	Czechoslovakia	1960-68	Legal	--	--	--	1.4	--	--
Heczko (1970)	Czechoslovakia	1967-69	Legal	--	--	--	No	No	--
Hren (1974)	Yugoslavia	1971-73	Legal	--	No	--	--	--	--
Hogue (1975)	Yugoslavia	1968-69	Legal	No	--	No	No	--	--
Voight (1975)	East Germany	1972-74	Legal	--	--	--	No	--	--
Knorre (1976)	East Germany	1972-74	Legal	--	--	--	4.1	Yes[h]	--

*Relative risk of pregnancy outcome among women having previous induced abortions compared to controls
†Preliminary report
--Not studied
No = No significant relationship
[a]Increased risk of spontaneous abortion at 16-20 weeks
[b]With ≥ 2 previous abortions, not with 1 abortion
[c]Increased risk of antenatal hemorrhage, preeclampsia and prolonged labor
[d]Risk of spontaneous abortion increased with number of previous abortions
[e]Risk of prematurity increased with number of previous abortions
[f]Increased risk of retained placenta
[g]Increased risk of antenatal and postpartum hemorrhage
[h]Increased risk of prolonged labor and retained placenta
[i]Increased risk of retained placenta

comes they evaluated.[6,8] Preliminary results from five other American studies are available.[2,4,9,10,12] Some imply that shortened gestation in subsequent pregnancies, either as spontaneous abortion or premature labor, may be associated with prior induced abortion.[4,9,10] Two preliminary studies[4,12] have found no association between induced abortion and either low-birth-weight infants or complications of pregnancy, while one report did.[10] No effect of previous abortions was found on subsequent birth defects among any of the American studies.[2,4,6,10,12] Because further analysis may affect the final results, the ultimate interpretation of these preliminary reports should be based on the final published analysis.

In analytic studies from nine other countries, the results have also formed no consistent pattern (Table III). The one study which found a risk of subfecundity was conducted in a study where abortion was illegal; the others have found no effect. Two of five investigations showed abortion was associated with ectopic pregnancy; six of eight, with spontaneous abortion; 10 of 15, with prematurity; four of six, with complicated preg-

nancies; and one of one, with birth defects.

What To Tell Your Patient

For the clinician counseling a pregnant woman about the risks of pregnancy termination versus those of pregnancy continuation, the results of the published studies provide no answers. In view of the inconsistencies among the above analytic studies, my suggestion is to advise patients that the current data do not support firm conclusions about induced abortion's either causing or not causing any of the alleged long-term complications. If some late sequelae are eventually shown to be casually associated with prior induced abortion, it is likely that they are related to particular abortion techniques, such as the manner and caliber of dilatation, the method of curettage used to evacuate the uterus or the stage of gestation at which the abortion was performed. Moreover, if present, any risks of subsequent adverse reproductive outcomes would probably be increased for women who had more than one previous induced abortion.

Given the uncertainty of the present state of knowledge about the long-term complications of induced abortion, the dogmatic statements contained in the current "informed consent" provisions of local, state and national regulations are misleading. Pregnant women who may wish to have subsequent pregnancies should receive the most accurate information available to allow them to assess the risks of terminating their pregnancies versus the risks of continuing them. My advice is to tell them that we currently do not know the answer.

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References for analytic studies in countries other than the United States are available upon request from the author.

Document #13

Induced Abortion and Spontaneous Fetal Loss In Subsequent Pregnancies

CHIN S. CHUNG, PHD, ROY G. SMITH, MD, MPH,
PATRICIA G. STEINHOFF, PHD, AND MING-PI MI, PHD

Abstract: The effect of induced abortion on spontaneous pregnancy loss in subsequent pregnancies was studied based on 3,416 pairs of matched data in a follow-up investigation. Pregnancy outcome was examined also in relation to abortion procedure, gestation length at time of abortion, and number of previous abortions. In general there was no significant association between prior induced abortion and risks of pregnancy loss with the relative risks of 1.10, 0.88, and 0.81 for the first to third trimester respectively. A slight increase of first-trimester spontaneous loss was noted with the D&C/Suction procedure and early induced abortion (<9 weeks). The D&C procedure was associated with non-significant increase of second-trimester loss with the relative risk of 1.59. *(Am J Public Health* 1982; 72:548–554.)

Induced abortion is considered the most commonly used surgical procedure in the United States[1] and accounts for about 30 per cent of all known pregnancies.[2] Reported results of studies relating history of induced abortion to subsequent spontaneous abortion demonstrate inconsistencies among different countries as shown by summaries of international studies[2,3] and a World Health Organization study spanning several countries.[4] These conflicting results are difficult to evaluate in view of the great variations among countries in the legal status of induced abortion, socioeconomic condition, health care standard, abortion procedure, and study design.

Conflicting observations also prevail in studies carried out in the United States, where conditions could be considered more homogeneous. On the one hand, no association between prior induced abortion and subsequent spontaneous abortion was detected by Kline, *et al,* in New York in a case-control study[5] and by Daling and Emanuel in Seattle in a matched-pair cohort study.[6] On the other hand, Harlap, *et al,* reported an increase of mid-trimester spontaneous abortion among nulliparous women with prior induced abortion compared with control nulliparous women in the San Francisco Bay area.[7] The increase was largely limited to women who had abortion procedure in early years after the legalization of abortion. More recently, Levin, *et al,* reported a twofold to threefold increase in risk of first-trimester spontaneous abortion and losses up to 28 weeks of gestation only for women who had two or more prior induced abortions.[8]

The present study reports the results of a relatively large follow-up investigation in which outcomes of subsequent pregnancies of a cohort of women with a history of induced abortion are compared with those of a matched control group. Furthermore, these pregnancy outcomes were evaluated specifically in relation to information on abortion procedure used, use of laminaria* in dilatation of cervix, and other pertinent reproductive characteristics of the women at the time of induced abortion.

Materials and Methods

Subsequent pregnancies were followed up on a cohort of women who had documented records of induced abortion. The abortion cohort of 16,961 women with 18,786 abortions is made up of nearly all women who had experienced induced abortion during the period of March 1970 through June 1974 in the state of Hawaii following the legalization of induced abortion in March 1970. The cohort was derived from an earlier research project to study demographic, behavioral, and medical aspects of women undergoing induced abortion.[9–14] Medical and demographic information was obtained from hospital records on each induced abortion by personnel trained and asigned in the earlier project. The information included date of abortion, length of gestation at time of abortion, abortion procedure used, use of laminaria, complications associated with procedure, and reproductive history.

In order to follow this cohort for subsequent pregnancies, their records were linked with vital registration records of live births and spontaneous fetal deaths reported to the State Department of Health for the period of 1970 through 1976. The State of Hawaii requires reporting of fetal death at any stage of gestation. Record linkage was based on first name, maiden last name, age, and race of the women, and date and hospital of the subsequent event. Hospital records

Address reprint requests to Chin S. Chung, PhD, Professor of Public Health and Genetics, Department of Public Health Sciences, University of Hawaii, 1960 East-West Road, Honolulu, HI 96822. Dr. Smith is Professor of Public Health, Department of Community Health Development; Dr. Steinhoff is Professor of Sociology; and Dr. Mi is Professor of Genetics; all are with the University of Hawaii. This paper, submitted to the Journal July 9, 1981, was revised and accepted for publication February 1, 1982.

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*Laminaria is a dried marine plant that expands in the presence of moisture.

of these pregnancy outcomes were reviewed for detailed information on type of pregnancy outcome, reproductive history, weeks of gestation, pregnancy complications, labor and delivery complications, postpartum complications, birthweight, and congenital malformations.

A control group was formed as follows. For each woman who had a subsequent pregnancy outcome in the abortion cohort, one woman was selected from the merged file of individuals who had either live birth or spontaneous abortion. The file was derived from the reports of live births and spontaneous abortions of the Hawaii State Health Department. Excluded from the file were all women who had any record of induced abortion as ascertained through the induced abortion cohort and/or the separate file of induced abortions registered with the Health Department. In this process the control women were matched pairwise with the abortion women for race, age, and time of the pregnancy outcome (± one month).

For the purpose of this study, races were classified into five categories: Caucasians, Hawaiians and part-Hawaiians, Filipinos, Orientals, and Others. Caucasians and Filipinos represent the respective racially unmixed groups. Orientals include the unmixed groups of Japanese, Chinese, and Koreans, who are more homogeneous in their cultural and socioeconomic background. Hawaiians and part-Hawaiians were pooled together because of a small number of unmixed Hawaiians and some cultural similarity. The "Other" group consists of heterogeneous entities including other unmixed ethnic groups and interracial crosses excluding part-Hawaiians. Reproductive history of the woman was not considered in the matching process since the information was seldom available in fetal death certificates. Hospital records of the control pregnancies were searched and reviewed as with the abortion cohort pregnancies. For the purpose of data analysis, spontaneous fetal loss was classified into three groups on the basis of completed gestation length: first-trimester (≤14 weeks), second-trimester (15–27 weeks), and third-trimester (≥28 weeks) losses.

The matching process produced a total of 3,589 pairs of observations for the abortion and control groups. However, detailed reviews of hospital records revealed a small number of incorrect entries among those fetal deaths reported as spontaneous fetal deaths to the State Health Department. There were 12 cases of menstrual induction (eight in the abortion group and four in the control group), six cases of septic abortions equally distributed between the two groups, and 18 cases of induced abortion (13 in the abortion group and five in the control group). All of the pairs with these types of discrepancies were excluded from pairwise comparisons. Excluded also were those pairs of observations in which intrauterine devices (IUD) *in situ* were detected at the time of delivery or spontaneous abortion and the control women who had documented history of induced abortion (79 cases) based on hospital records. When these exclusions were made, there were 3,416 pairs of observations for matched comparison. However, all valid data were used when analysis was confined to the abortion cohort.

The data presented an interesting problem from an analytical point of view because of the fact that they were matched on some covariables but not on others. The methods for matched data developed for case-control studies[15,16] are not directly applicable to the present data. We decided against use of a method modified from the case-control method[15] (personal communication with Dr. Holford) because of too stringent selection of data resulting in great loss of information. The observation of Rubin[17] that "the combination of regression adjustment in matched samples generally produces the least biased estimate" of the effect led us to choose the method of logistic regression[18] for analysis of the present data. In addition, the technique can accommodate as many covariables as needed and lead to estimation of relative risk (odds ratio) adjusted for the covariables. Furthermore, the result of the analysis could be used in adjusting the data for evaluation of abortion techniques to be discussed later. Variables considered in addition to the matched variables were resident island (Oahu = 1, otherwise

TABLE 1—Coefficients of Logistic Regression and Their Standard Errors for Spontaneous Fetal Losses by Trimester

	First-Trimester	Second-Trimester	Third-Trimester
Constant	2.0831	1.1585	−0.3202
Year of Event	−0.0930 ± 0.0374*	−0.0468 ± 0.0598	−0.0898 ± 0.1210
Mother's Age	0.0712 ± 0.0130**	0.0226 ± 0.0207	0.1035 ± 0.0419*
Race			
Hawaiian or Part-Hawaiian	−0.4523 ± 0.1475**	−0.1910 ± 0.2360	0.0795 ± 0.4774
Filipino	−0.1609 ± 0.1637	−0.5177 ± 0.2623*	−0.3180 ± 0.5303
Oriental	0.0537 ± 0.1427	−0.3697 ± 0.2285	−0.5256 ± 0.4622
Other	−0.4301 ± 0.2285	−0.0804 ± 0.3659	0.1830 ± 0.7400
Residence Island	0.0059 ± 0.1389	0.3627 ± 0.2226	−0.3679 ± 0.4501
Pregnancy Order	0.0445 ± 0.0377	0.0405 ± 0.0604	−0.1911 ± 0.1222
Current Marital Status	1.2073 ± 0.1468**	0.8459 ± 0.2342**	1.0689 ± 0.4733*
History of Induced Abortion	0.0943 ± 0.1068	−0.1331 ± 0.1710	−0.2143 ± 0.3459
Exposure Odds Ratio and Confidence Limits	1.10 (0.89–1.35)	0.88 (0.63–1.22)	0.81 (0.41–1.59)

*P < .05
**P < .01

TABLE 2—Matched-Pair Analysis of First- and Second-Trimester Spontaneous Fetal Loss for Specific Combinations of Reproductive History

Abortion	Control	Number of Pairs: First-Trimester	Number of Pairs: Second-Trimester
A1	S1		
+	+	0	0
+	−	1	0
−	+	3	1
−	−	36	39
Total		40	40
χ^2_1		0.25	0
RR (C.L.)		0.33(−0.42–1.09)	−
A1	P1		
+	+	2	0
+	−	13	4
−	+	13	5
−	−	305	324
Total		333	333
χ^2_1		0.04	0
RR (C.L.)		1.00(0.23–1.77)	0.80(−0.25–1.85)
A1	P0		
+	+	3	0
+	−	31	13
−	+	24	18
−	−	476	503
Total		534	534
χ^2_1		0.65	0.52
RR (C.L.)		1.29(0.60–1.98)	0.72(0.21–1.24)

A1 = nulliparous with single induced abortion; S1 = nulliparous with single spontaneous abortion; P1 = only single previous birth; P0 = no previous pregnancy.

= 0), pregnancy order, and marital status of woman (married now = 0, not married = 1).

Possible effects of induced abortion were further studied by making comparisons between specific subgroups of the abortion and control groups selected on the basis of reproductive history of the women with due allowance for the matched variables. This analysis included comparisons of pregnancy outcomes of nulliparous women of the abortion cohort who had only one previous induced abortion with three subgroups of the control women: pregnancies of women with no prior pregnancy, only one prior spontaneous abortion, or only one prior live birth. The nulliparous abortion cohort is of special interest because this group of women may want children later.

Finally, factors associated with induced abortion at the time of procedure were studied in relation to pregnancy outcome by comparing subgroups of the abortion group with the control on the data stratified by multivariate confounder scores of Miettinen.[19] Essentially this analytical method enables a comparison of two groups adjusting for a number of confounding variables. The discriminant function coefficients used were the same as the logistic regression coefficients described above on the same set of confounder variables. Factors studied in relation to abortion were maternal age and gestation weeks at time of procedure, number of previous induced abortions experienced, type of procedure, and use of laminaria.

Factors associated with induced abortion were further studied within the abortion cohort pregnancies in order to check consistency with the earlier comparison and to allow for correlation between certain factors. Thus possible effects of use of laminaria, multiple induced abortions, and gestation stage at induced abortion were examined by the χ^2 method of Mantel and Haenszel[20] on data stratified by abortion procedure and pregnancy order of the subsequent pregnancy. This analysis was limited to first- and second-trimester fetal losses because of small numbers of observations in third-trimester pregnancy loss.

Results

Table 1 shows the results of the logistic regression analysis of spontaneous fetal losses by trimester. Fetal losses of all types were consistently associated with marital status of the women, with a significantly higher risk for unmarried women. When all of the covariables were allowed for, none of the three types of fetal losses was found to be significantly associated with history of induced abortion. The estimated relative risks with their 95 per cent confidence limits were 1.10 (0.89–1.35), 0.88 (0.63–1.22), and 0.81 (0.41–1.59) for first-, second-, and third-trimester fetal losses respectively.

Table 2 shows the matched comparisons of first- and second-trimester fetal loss rates of the abortion cohort pregnancies with a history of only one induced abortion (A1) with the three subgroups of control pregnancies, those preceded by only one spontaneous abortion (S1), only one live birth (P1), and no previous pregnancy (P0). Because of limited data, third-trimester fetal loss was excluded from this comparison. In these comparisons the originally matched variables remained matched resulting in considerable reduction in sample size. The association was tested by McNemar's χ^2 test and the relative risk was estimated from discordant pairs.[21] There was little information for the comparisons of the A1 and S1 groups. For the A1 vs P1 contrast, the rates of first- and second-trimester fetal losses were similar with the respective relative risks of 1.00 and 0.80. The A1 vs P0 comparisons had more stable estimates of rates and relative risks of fetal losses, although no significant association was found between previous induced abortion and first- or second-trimester spontaneous loss with the respective relative risks of 1.29 and 0.72.

The results of testing specific factors associated with immediately previous induced abortion are summarized in Table 3 in terms of relative risk (RR) based on the method of Mantel-Haenszel as applied to the data stratified by the multivariate confounder scores. The data were grouped into five strata. Each subgroup of the cohort pregnancies characterized by a factor at previous induced abortion (e.g., use or non-use of laminaria) was compared with the entire control group with 3,416 observations for test of association with one degree of freedom. The relative risk estimate in Table 3 represents the ratio of the risks (odds) of specific type of fetal loss for the abortion cohort to that of the control group after adjusting for the set of confounding factors described earlier.

TABLE 3—Relative Risks of Spontaneous Fetal Loss for Subsequent Pregnancies of Women with History of Induced Abortion as Classified by Variables Associated with Induced Abortion

		Relative Risk for Fetal Loss		
		First-Trimester	Second-Trimester	Third-Trimester
Procedure				
D&C		0.97	1.59	—
Suction		1.06	0.88	0.90
D&C/Suction		1.33*	0.78	0.79
Other		1.06	0.45	0.89
Use of Laminaria	No	1.14	0.94	0.31
	Yes	1.10	0.76	1.04
Gestation Weeks at Last Induced Abortion	<9	1.40**	0.91	0.54
	≥9	0.95	0.87	0.84
Number of Previous Induced Abortions	1	1.15	0.91	0.61
	>1	1.01	0.80	1.68

*P < .05
**P < .01

Of the four factors studied (abortion procedure, use of laminaria, gestation length at time of procedure, and number of previous induced abortions), the D&C/Suction procedure and early induced abortion (<9 weeks of gestation) were found to be significantly related to first-trimester spontaneous abortion. The respective relative risks indicate approximately 30 per cent and 40 per cent increases in the risk due to these factors. There was an apparent increase in the relative risk of second-trimester fetal loss associated with the use of D&C as abortion procedure (RR = 1.59), although the increase was not statistically significant.

The factors characterizing previous abortion were further examined in relation to other possible confounding variables. Table 4 shows the risks of fetal losses of the first two trimesters for second pregnancies of the women whose only previous pregnancy was terminated artificially according to the abortion method used. The highest frequency of first-trimester fetal loss was observed in the D&C/Suction procedure (χ^2_1 = 4.87, P < .05) with no evidence of heterogeneity among other procedures (χ^2_2 = 0.41, P > .05), whereas no significant association was detected for second-trimester loss. These observations are consistent with the result of the earlier analysis (Table 3).

Table 5 compares the frequencies of spontaneous fetal losses between the abortion cohort women whose last induced abortion was aided by laminaria for cervical dilatation and a control group in which no laminaria was employed. The risk of pregnancy losses tends to be greater for pregnancies subsequent to the induced abortion when no laminaria are used, although none of the associations proved to be significant.

Table 6 shows the relationship of completed gestation weeks with the risks of first two trimester spontaneous losses stratified by pregnancy order and abortion procedure. This subset of data limited to the abortion cohort corroborates the earlier finding of a significant association of gestation time with first-trimester spontaneous abortion (χ^2_1 = 9.36, P < .005) with about 55 per cent increase of the risk for early abortion (<9 weeks of gestation) over late abortion (≥9 weeks). No such association was detected for second-trimester loss in agreement with the earlier observation.

TABLE 4—First- and Second-Trimester Spontaneous Fetal Loss (SA) by Method of Abortion Procedure among Pregnancies Whose Only Prior Pregnancy Was Terminated by Induced Abortion

		D&C	Suction	D&C/S	Other	Total
First-Trimester	SA	11	34	41	12	98
	No SA	208	673	484	189	1554
	Total	219	707	525	201	1652
	p	.0502	.0481	.0781	.0597	.0593
Second-Trimester	SA	3	17	7	1	28
	No SA	216	690	518	200	1624
	Total	219	707	525	201	1652
	p	.0137	.0240	.0133	.0050	.0169

Table 7 compares spontaneous fetal losses between single and multiple induced abortion groups. The data also confirm the earlier findings of no significant differences between the two groups both for first- and second-trimester spontaneous losses.

Discussion

Our study has demonstrated no significant relationship between induced abortion and risk of spontaneous fetal loss in any trimester of subsequent pregnancies, although little information was available for third-trimester. The relative risks from the logistic regression analysis were 1.10, 0.88, and 0.81 for fetal losses in the first-, second-, and third-trimester, respectively. The corresponding estimates of the relative risks from a large body of unmatched data** are 1.11, 0.97, and 0.66, indicating no systematic bias of the logistic regression analysis of the matched data. Our findings are consistent with Kline, *et al.*[5] and Daling and Emanuel,[6] while at variance with the results of others.[4,7,8]

Summarizing three major worldwide studies, Tietze[2] noted that two out of seven comparisons showed significant increases in mid-trimester fetal loss among nulliparous abortion women relative to the control women of gravidity one. One of these positive findings involved a group of women with two or more induced abortions in California[7] and the other study was carried out in an eastern European country.[4] These data represent situations distinct from that for the present study. However, the summary raises an interesting question as to the power of test detecting a specified difference. In order to examine this question, we calculated

**Chung CS, Steinhoff PG, Smith RG, Mi MP: Effects of induced abortion on subsequent reproductive function and pregnancy outcome. Final Report to National Institute of Child Health and Human Development, 1981. (In press, East-West Population Institute Monograph Series, Honolulu, HI: East-West Center, 1982.)

TABLE 5—First- and Second-Trimester Spontaneous Fetal Loss (SA) of Subsequent Pregnancies by Use of Laminaria with Data Classified by Pregnancy Order and Abortion Procedure

			No Laminaria		Laminaria	
	Pregnancy Order	Abortion Procedure	Total	Proportion of SA	Total	Proportion of SA
First-Trimester	2	D&C	195	.0513	24	.0417
		Suction	483	.0538	224	.0357
		D&C/Suction	346	.0838	179	.0670
		Other	155	.0710	46	.0217
	3+	D&C	270	.0630	20	.0500
		Suction	552	.0779	191	.0733
		D&C/Suction	511	.0724	188	.0957
		Other	81	.0617	54	.0556
		Total	2593	.0686	926	.0626
		χ^2_1 = 0.40 RR = 1.12 (0.75–1.49)				
Second-Trimester	2	D&C	195	.0154	24	0
		Suction	483	.0269	224	.0179
		D&C/Suction	346	.0145	179	.0112
		Other	155	0	46	.0217
	3+	D&C	270	.0519	20	.0500
		Suction	552	.0236	191	.0105
		D&C/Suction	511	.0235	188	.0266
		Other	81	.0123	54	.0370
		Total	2593	.0235	926	.0184
		χ^2_1 = 0.17 RR = 1.17 (0.44–1.90)				

the power of detecting a doubled risk (RR = 2) from our data using the conditional power function.[22] The power calculated from the overall matched data reached nearly 100 per cent indicating that in no way could we miss such a magnitude of the effect of induced abortion, if present in our data. Therefore, we conclude that if there were any effect, it must be very small.

It has been hypothesized that instrumental dilatation followed by curettage (D&C) leads to cervical incompetence resulting in higher risk of second-trimester fetal loss.[4-7] Our data provide no convincing support to the hypothesis. The D&C procedure produced no significant increase in the risk of mid-trimester spontaneous abortion when compared with the control or other types of abortion procedure within the abortion cohort women. Furthermore, the use of laminaria at the time of prior induced abortion did not reduce the risk of mid-trimester spontaneous loss substantially. Nevertheless, the estimated relative risk was in the direction expected from

TABLE 6—First- and Second-Trimester Spontaneous Fetal Loss (SA) of Subsequent Pregnancies by Gestation Weeks at Previous Induced Abortion with Data Classified by Pregnancy Order and Abortion Procedure

			< 9 Weeks		≥ 9 Weeks	
	Pregnancy Order	Abortion Procedure	Total	Proportion of SA	Total	Proportion of SA
First-Trimester	2	D&C	98	.0612	121	.0413
		Suction	323	.0619	385	.0364
		D&C/Suction	238	.0840	287	.0732
	3+	D&C	140	.0429	150	.0800
		Suction	341	.1085	401	.0499
		D&C/Suction	317	.1009	381	.0604
		Total	1457	.0830	1725	.0551
		χ^2_1 = 9.36 RR = 1.55 (1.10–2.00)				
Second-Trimester	2	D&C	98	0	121	.0248
		Suction	323	.0341	385	.0156
		D&C/Suction	238	0	287	.0244
	3+	D&C	140	.0571	150	.0467
		Suction	341	.0293	401	.0125
		D&C/Suction	317	.0095	381	.0367
		Total	1457	.0220	1725	.0243
		χ^2_1 = 0.15 RR = 0.89 (0.37–1.40)				

TABLE 7—First- and Second-Trimester Spontaneous Fetal Loss (SA) by Number of Previous Induced Abortions with Data Classified by Abortion Procedure

		Two or More Previous Abortions		One Previous Abortion	
	Abortion Procedure	Total	Proportion of SA	Total	Proportion of SA
First-Trimester	D&C	43	.0698	244	.0615
	Suction	124	.0726	602	.0764
	D&C/Suction	170	.0647	506	.0850
	Other	37	.0811	97	.0515
	Total	374	.0695	1449	.0752
	χ^2_1 = 0.09 RR = 0.91 (0.50–1.32)				
Second-Trimester	D&C	43	.0465	244	.0533
	Suction	124	.0242	602	.0199
	D&C/Suction	170	.0176	506	.0257
	Other	37	.0270	97	.0206
	Total	374	.0241	1449	.0276
	χ^2_1 = 0 RR = 0.91 (0.21–1.61)				

the hypothesis: 1.59 for the D&C procedure compared with the control pregnancies with no prior induced abortion.

First-trimester spontaneous loss needs further elaboration because of its relatively higher relative risk and observed significant association with abortion procedure and gestation time of the prior induced abortion. The 10 per cent increase in the risk is admittedly small and can be dismissed as insignificant. However, there is a serious problem associated with early spontaneous abortion as a sequela of induced abortion in our study and other previous studies. The problem is related to competition between spontaneous fetal loss and induced abortion among women who are determined not to carry the pregnancy to term (unwanted pregnancies). Such pregnancies must result in either spontaneous abortion before an intended termination or induced abortion. When the outcome is spontaneous abortion, it is included as an observation in the sample whether the study is a case-control or cohort design, whereas the pregnancy is excluded from the sample if terminated as an induced abortion. This problem need not complicate a comparison for rates of spontaneous loss in a cohort study if the exposure and control groups have a comparable proportion of such women. However, it is known that the proportion of unwanted pregnancies is higher among women with prior induced abortion.[2,23] This tends to increase the rate of spontaneous abortion in the abortion cohort. Using the knowledge that the "competition" between spontaneous and induced abortion reduces the spontaneous abortion rate to about half of the level without such "competition",[24] we can derive expressions of unbiased frequency of spontaneous abortion in the absence of adverse effect of prior induced abortion as

$$s'_c = \frac{s(1 + p_0)}{2p_0 + s(1 - p_0)} \text{ for the control group and}$$

$$s'_a = \frac{s(1 + p_1)}{2p_1 + s(1 - p_1)} \text{ for the abortion cohort,}$$

where s is the general rate of spontaneous abortion, p_0 is the proportion of *wanted* pregnancies in the control, and p_1 is the proportion of *wanted* pregnancies in the abortion cohort. Wanted pregnancy is the complement of unwanted pregnancy. Then the relative risk (odds ratio) under either cohort or case-control design can be expressed as $(p_0 + p_0p_1)/(p_1 + p_0p_1)$ as discussed briefly in an earlier communication.[25]

Unfortunately, no reliable data on p_0 and p_1 are available at present. However, we could make rough estimates of these parameters using the existing data in Hawaii.[23,26] These are .80 and .55 for p_0 and p_1, respectively, and substituting these values into the formula leads to a relative risk of 1.25 for first-trimester spontaneous abortion even in the absence of any adverse effect of induced abortion. The value is larger than our overall estimate of the relative risk (1.10) and smaller than the maximum estimate of 1.29 (Table 2). Therefore, we conclude that the small amount of excess risk in first-trimester spontaneous abortion observed for the abortion cohort women could be accounted easily by the sampling problem.

Smoking and alcohol consumption are known to be associated with an increase in spontaneous abortion. Unfortunately, no direct information is available on these confounders in our samples. But interview data on small samples of the abortion and control groups showed no significant differences between them in their habits of smoking and alcohol consumption.***

There is a question as to whether our sample is representative of the original abortion cohort women. Our ancillary study*** showed that there was no major difference in outmigration rates between a sample of the abortion cohort and a control sample; the maximum estimates of outmigration rates were 23.3 per cent and 19.4 per cent for the respective samples. Furthermore, it is interesting to observe that demographic characteristics of those cohort women with one or more subsequent pregnancies were more similar to the general population than the original cohort.*** There-

***See Chung, et al, footnoted earlier.

fore, we have no reason to believe that outmigration would have distorted the results of our analysis.

We have observed some increase in the risk of first-trimester spontaneous abortion in association with the D&C/Suction procedure and early gestation time of the prior induced abortion. The fact that both of those antecedent factors are related to early gestation period of the prior induced abortion may have some significance, but a physiological basis, if any, for the observation is not clear. In any event, the overall data suggest that the general adverse effects of these factors must be too small to be of any major consequence.

Harlap, *et al*,[7] found an increase in second-trimester spontaneous abortion among nulliparous women with prior induced abortion particularly among those women with multiple induced abortions in comparison with the control women. Levin, *et al*,[8] observed significant increases in the risk of both first- and second-trimester spontaneous pregnancy losses among women with multiple induced abortions. None of these studies adjusted for the bias in the estimates of the relative risk due to the difference in the proportions of wanted pregnancies between the study and control groups as discussed above. As pointed out elsewhere,[25] overestimation of the relative risk becomes more serious for repeat aborter women because the probability of unwanted pregnancy increases with number of induced abortions.[2] Thus it is likely that at least part of the increased risks of spontaneous pregnancy loss observed by these investigators may be explained by the bias.

The present paper has presented a small segment of a larger study to investigate many aspects of long-term sequelae of induced abortion including prematurity, short gestation, ectopic pregnancy, pregnancy and labor complications, and congenital malformations in addition to fetal loss. Further study is in progress on the relationship between induced abortion and subsequent fetal loss.

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Document #14

TEENAGE PREGNANCY: THE PROBLEM THAT HASN'T GONE AWAY

Introduction

In 1976, The Alan Guttmacher Institute published *11 Million Teenagers*. It was primarily a statistical compilation in chart form of what was then known about adolescent sexuality, contraceptive use, pregnancy, childbirth, abortion and the health and social consequences of teenage childbearing. The chartbook specified services available to prevent adolescent births and to help pregnant teenagers and teenage parents to cope with the serious problems that they faced. More than 220,000 copies of *11 Million Teenagers* were sold and distributed.

The widespread popularity of *11 Million Teenagers* was in large measure due to growing public awareness that teenage sexual activity and pregnancy are not the special problems of any one economic, ethnic or social group, but affect young people from all regions of the country, from the cities and the farms, and from families of all socioeconomic levels, racial groups and religious denominations.

Most people agreed with the major recommendations in *11 Million Teenagers*—to prevent teenage pregnancy through realistic sex education programs and birth control services, to provide pregnant teenagers with an informed choice of maternity or abortion services, and to give pregnant teens, and teenage parents and their children, the health and social services and financial support that they need. Some, however, expressed concern that increasing the availability of sex education and birth control lowered moral standards and

encouraged sexual activity among young people, resulting in increased recourse to abortion. Others felt that there had not been sufficient emphasis on the social and behavioral factors involved in teenage pregnancy. The solution of the problem, they maintained, required fundamental changes in family relationships and values to which sex education or the increased availability of medical services such as contraception could contribute little. Still others noted that since the teenage birthrate was in fact declining, the problem was on its way to resolution.

The adolescent birthrate, it is true, has been going down, but the *pregnancy rate* has continued to increase. In 1974, the year referred to in *11 Million Teenagers*, there were one million adolescent pregnancies. By 1978, the year referred to in this publication, that number had increased by 100,000. More than one in 10 teenagers gets pregnant each year, and the proportion is rising. If patterns do not change, four in 10 young women will get pregnant at least once while still in their teens. Despite the declining teenage birthrate, there are 1.3 million children now living with teenage mothers, about half of whom are unmarried. An additional 1.6 million children under age five are living with mothers who were teenagers when they gave birth.

The increase in adolescent pregnancies stems largely from an increase in the number of teenagers who are sexually active. Rising and more consistent use of contraception has not kept pace with this increase. Of course, if

more teenagers abstained from sexual activity, the pregnancy rate could be brought down without increased recourse to contraception. As we will show, however, it is the exceptional young man or woman who gets through the teen years without engaging in sexual intercourse. We live in a society in which marriage and childbearing are being delayed, in which cohabitation is more widespread and accepted and in which all the media glorify youth and sexuality. There is no evidence that in such a setting simply increasing teenagers' fear of pregnancy by barring them from contraceptive and abortion services would do much to decrease their sexual activity. Keeping birth control services and information from teenagers is a singularly cruel as well as ineffective punishment to inflict on young people for responding to messages that many adults may deplore, but appear unable to change. Too many teenagers, far from being encouraged by the availability of birth control, experiment with sex for many months before ever using contraceptives; many, in the meanwhile, become pregnant.

It is a safe assumption that American young people have never embodied the ideal of premarital chastity, even in the days when marriage occured at much younger ages. Premarital pregnancy, out-of-wedlock childbirth and forced marriages of pregnant teenagers have always been common. What is new and probably responsible for increasing public concern about the problem is its increased visibility: The sight of pregnant teenagers is no longer uncommon in school classrooms (previously, a girl was automatically expelled from school if she became pregnant); surveys of teenage sexuality, contraceptive use, pregnancy, abortion and childbirth are widely publicized in the media; fewer teenagers marry to legitimate out-of-wedlock pregnancies, more often choosing either to exercise their new option of legal abortion or to bear and keep their child outside of marriage.

Facing the Facts

This new publication about teenage pregnancy is more comprehensive and detailed than its predecessor. It benefits from the considerable research undertaken in the 1970s. Although this new knowledge has not made us confident that the problem of teenage pregnancy can be solved quickly or simply, we do believe that it can be solved. We know that very few teenagers—very few, certainly, of the great majority who are unmarried—want to get pregnant or to have babies while they are so young. Still fewer of their parents want them to do so. Nor is there any benefit to the society from adolescent childbearing. On the contrary, it is costly to the society both in direct expenditures for health and social services and in the loss of the economic contribution that teenage parents might have made if their educations and vocational choices had not been circumscribed by early childbearing. We know that many teenagers are making great efforts to prevent pregnancy, that more of them are using contraceptives and using them earlier and more consistently than ever before. Many are doing so successfully. Yet pregnancy rates among U.S. teenagers are increasing, and teenage birthrates, though declining, are still among the highest in the world. The decline in births is largely contingent on continued access to legal abortions. While some teenagers, especially those who are older and married, may have births that are wanted and welcomed, the majority of adolescent births, and the overwhelming majority of youthful pregnancies, are unintended. It must be emphasized that unwanted pregnancies, not just unintended births, have adverse consequences for teenagers. Means to prevent both need to be extended.

As we have said, solution of this problem is not simple or single-faceted. In the pages that follow, we attempt to assemble the facts in a way that will make reaching a reasoned solution more possible and less painful than it has been in the past.

SECTION 4

Adolescent Births

The number and rate of births declined during the 1970s for all teenagers except those under age 15. However, the decline has been less steep than that among women in their 20s. What is more, despite the decrease, the U.S. teenage birthrate is higher than those of all but a handful of developed countries—higher even than the birthrates in several developing countries.

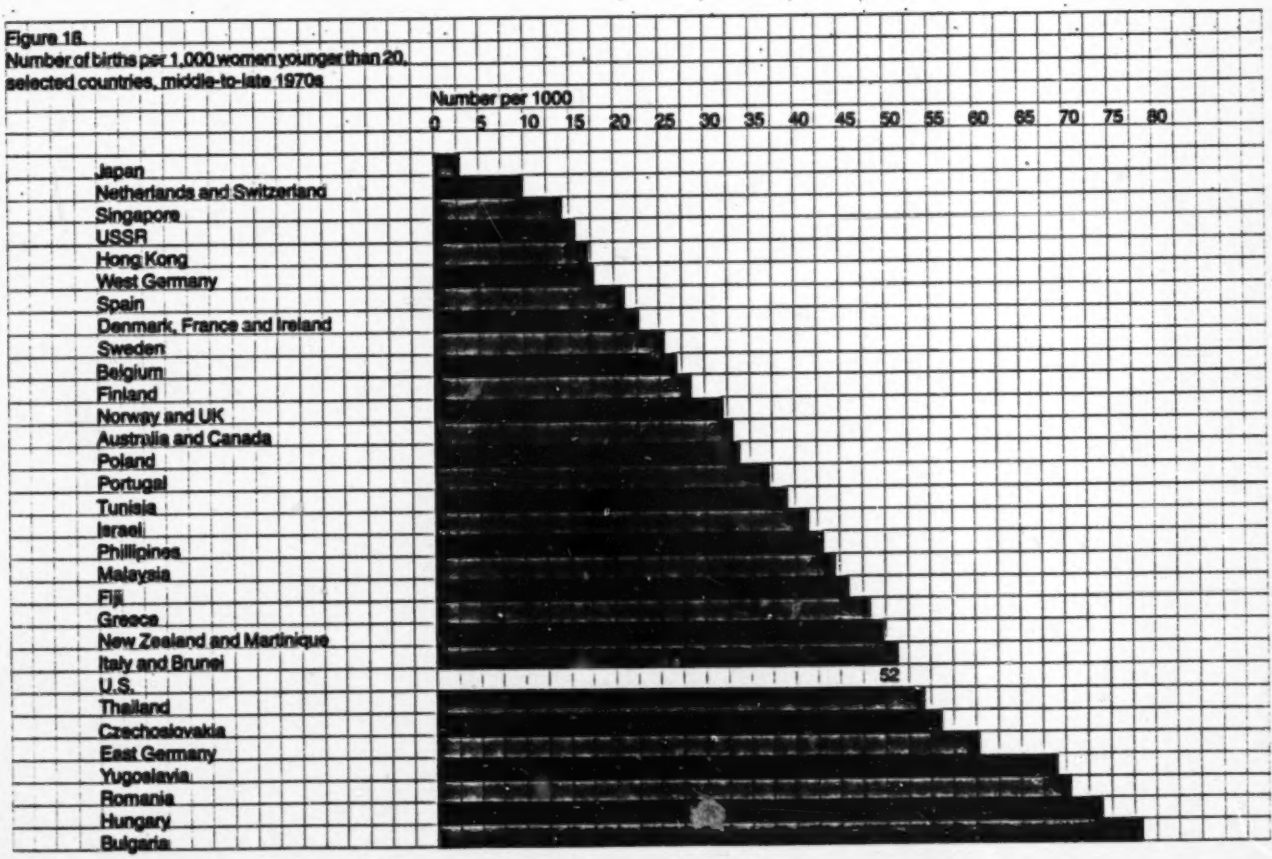
Although slowed because of the availability of legal abortion, the rise in the out-of-wedlock birthrate has continued among almost all groups of teenagers. The rise has been most steep among 15–17-year-old whites. The number of premaritally conceived births legitimated by marriage has been declining. Almost all unwed teenage mothers keep their children in the household with them.

All in all, 554,000 babies were born to teenagers in 1978, and 1.3 million small children were living with teenage mothers, half of whom were unmarried. An additional 1.6 million children under age five were living with mothers who were teenagers when they gave birth.

Teenage Birthrate in United States Is Among the World's Highest

About five percent of U.S. teenagers give birth each year. A higher proportion of adolescents become mothers in the United States than in any developed country, except for Czechoslovakia, East Germany, Yugoslavia, Romania, Hungary and Bulgaria. Japan's teenage birthrate is one-eighteenth as high; the Netherlands and Switzerland have rates just one-fifth as high as that of the United States. The U.S. rate is about three times higher than the Soviet Union's, and is about the same as that of Italy and Thailand. It is higher than the rate in such developing countries as the Philippines, Malaysia, Singapore and Tunisia.

Figure 18
Number of births per 1,000 women younger than 20, selected countries, middle-to-late 1970s

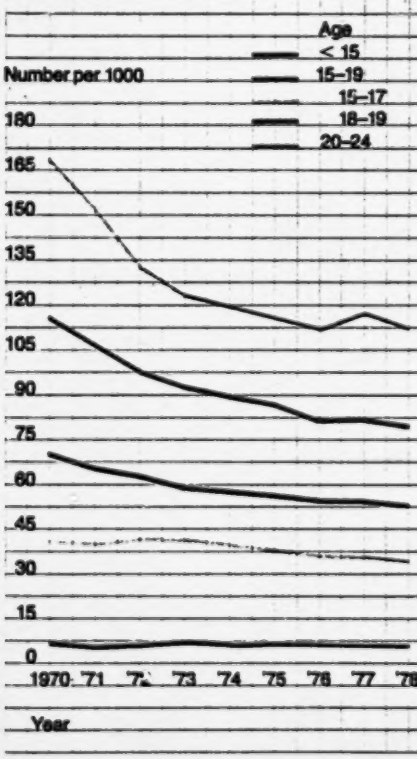


Teenage Birthrate Drops Much Less Sharply Than That of Women in their 20s

In 1978, three percent of 15–17-year-olds and eight percent of 18–19-year-olds gave birth. The U.S. teenage birthrate is relatively high, although it fell throughout the 1970s. It did not drop so steeply as the rate for women in their 20s, however. The younger the teenager, the smaller the birthrate decline: The rate for 20–24-year-olds fell by 33 percent between 1970 and 1978; for those aged 18–19, the decline was 29 percent; for 15–17-year-olds, it was 15 percent; and for girls under 15, there was no decline at all.

As might be expected, 78 percent of births to teenagers are first births. However, 18 percent are second births, and four percent are third or higher order births. The sooner a teenager gives birth after initiation of intercourse, the more likely she is to have subsequent births while still in her teens.

Figure 19.
Number of births per 1,000 women younger than 25, by age-group, 1970–1978



Teenage O.W. Birthrate Rising, But Increase Slowed by Abortion Use

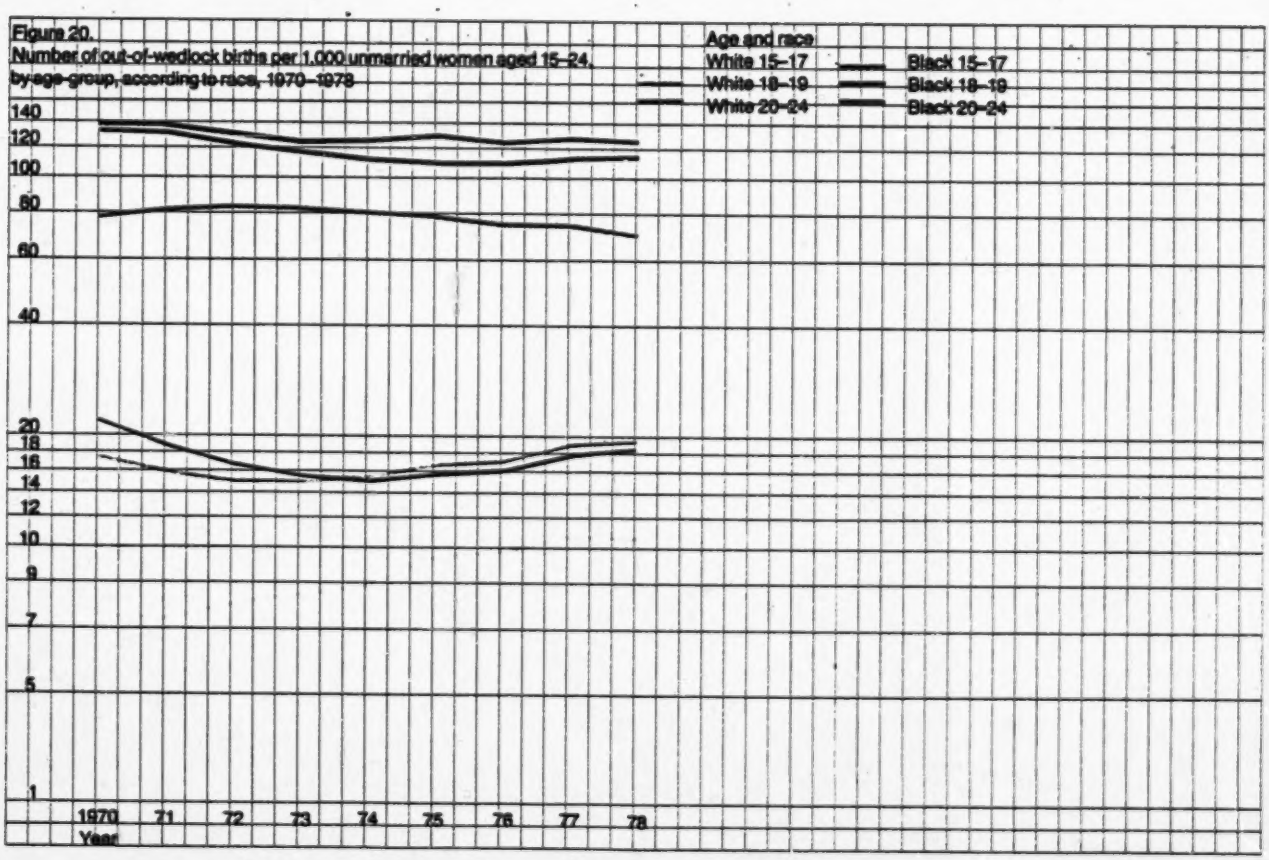
The rate of out-of-wedlock births to teenagers continued to rise over the 1970s, although at a much slower rate than it did in the 1960s (13 percent compared to 34 percent). Indeed, the liberalization of abortion laws in several large states in 1970, and abortion legalization nationwide in 1973, brought the historic increase in births to teenagers outside of marriage to a virtual halt in the first part of the decade; by the late 1970s, however, the rate again began to climb slowly, largely because fewer teenagers married to legitimate births.

Notably, the increase in the adolescent out-of-wedlock birthrate in the 1970s was confined to whites (a rise of 27 percent)—especially those aged 15–17, among whom there was a 40 percent rise. Rates among black teenagers actually declined in the 1970s by seven percent; among younger black teenagers, the decline was 10 percent, and it was continuous following the 1973 Supreme Court decisions legalizing abortion.

All in all, about 249,000 of the 544,000 out-of-wedlock births that occurred in 1978 were to women under age 20—about equally divided between 18–19-year-olds and those aged 17 and younger.

The out-of-wedlock birthrate among 20–24-year-olds declined more sharply than the teenage rate in the first half of the 1970s, but has been rising again almost as steeply since mid-decade.

Figure 20.
Number of out-of-wedlock births per 1,000 unmarried women aged 15–24, by age group, according to race, 1970–1978



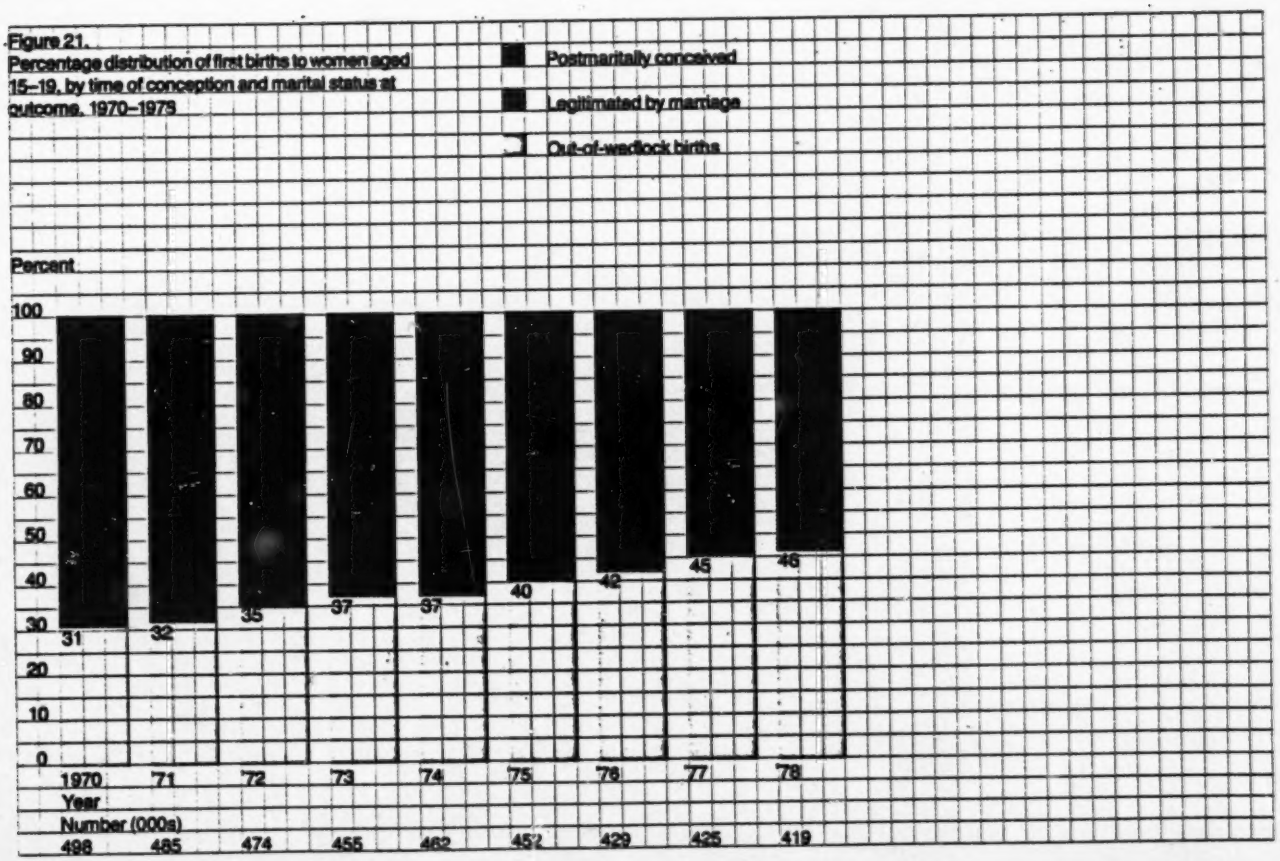
Teen Premarital Conceptions Rise; Fewer Legitimated by Marriage

While there was an increase in out-of-wedlock births among teenagers during the 1970s, there was a decline in the number of brides pregnant at marriage. There was an even sharper drop in the number of births conceived by teenagers following marriage. As a result, whereas 63 percent of first births to teenagers were the result of premarital conceptions in 1970, the proportion was 72 percent in 1978.

In 1970, 37 percent of first births to adolescents were the result of postmarital conceptions, 32 percent were from premarital conceptions delivered following marriage and 31 percent were delivered out of wedlock. By 1978, the picture had changed dramatically: Only 28 percent of first births had been conceived following marriage, 26 percent had been conceived premaritally but were delivered following marriage and 46 percent were out-of-wedlock births.

In 1978, as in 1970, close to half of all marital first births to teens were premaritally conceived.

Figure 21.
Percentage distribution of first births to women aged 15–19, by time of conception and marital status at outcome, 1970–1978



Only a Few Unwed Teen Mothers Give Up Children for Adoption or Care by Others

Although two-thirds of births to unmarried teenagers are unintended, unwed teenage mothers very rarely give up their babies for adoption or for care by friends or relatives. Ninety-six percent of unmarried teenage mothers—90 percent of white and virtually all of black mothers—keep their children with them (although in many cases, grandparents or other relatives help take care of the baby). In 1971, resort to adoption or care by others was more common: Eighty-seven percent of teen mothers kept their children—75 percent of white mothers and 94 percent of blacks. With legalization of abortion, many unwed teenagers choose to terminate unwanted pregnancies by abortion rather than to bear children that they would have to give up for adoption or for care by friends or relatives. If they do not have abortions, most keep their babies.

1.3 Million Children Now Living With 1.1 Million Teenage Mothers

Despite the decline in adolescent childbearing, there are about 1.3 million children now living with 1.1 million teenage mothers. More than half of these children are living with unmarried mothers. Two-thirds were born to mothers aged 17 or younger. There are an additional 1.6 million children under age five who were born to teenage mothers—1.2 million of them were born out of wedlock, and 635,000 were born to unwed mothers aged 17 or younger.

These figures give some idea of the magnitude of the problems involving teenage mothers and their children.

Figure 22
Percentage distribution of out-of-wedlock births resulting from first conceptions to women aged 15–19 in 1976, by disposition, according to race

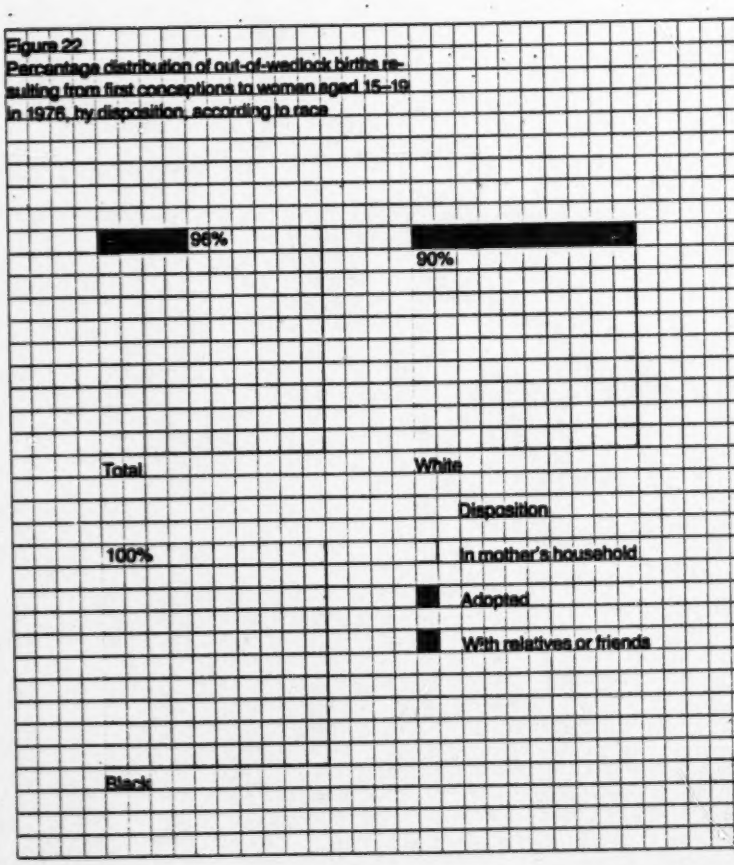
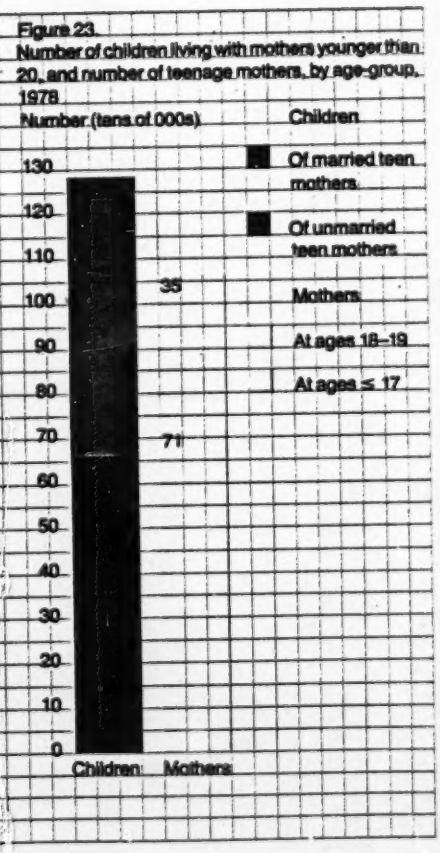


Figure 23
Number of children living with mothers younger than 20, and number of teenage mothers, by age-group, 1978



SECTION 5

Consequences of Teenage Childbearing

The health, social and economic consequences of teenage pregnancy are almost all adverse. Pregnancies that end in abortion or miscarriage are, at the least, upsetting and sometimes traumatic to the pregnant woman. They also involve some health risks to the teenager (although abortions before the 16th week of pregnancy are less dangerous than childbirth). Those pregnancies that result in births, however—most of which are unintended—have the most obvious negative consequences and are of most concern.

Babies born to teenage mothers are much more likely to die in the first year of life than those born to mothers over age 20. Maternal mortality and morbidity, and the risk of having a low-birth-weight infant, are also considerably greater among teenage mothers.

The most far-reaching consequence of teenage childbearing is the truncation of education among the young parents, and the resulting limitation of opportunities to gain skills needed to compete in society. Largely because of educational deficits, teenage parents are frequently unable to get decent jobs, and their family incomes tend to be much lower than those earned by other families.

The high probability that a teenage mother will bring up her child in a home with no father present is another reason her family income is so low. Even if they do marry, teenage parents are far more likely to become divorced or separated than are those who delay childbearing, and their babies are far more likely to spend a large part of their childhood in one-parent households. Alone, with small children, little education and few skills, it is small wonder that many teenage mothers find themselves on welfare or living below the officially designated poverty level. What income they have needs to be stretched to feed more young mouths, since teenage mothers have more births and more unintended births in the course of their reproductive lives than do those who delay childbearing until their 20s.

Living in poverty, lacking education and opportunity and being brought up in a one-parent home hurts the children of teenage parents, too. Such children are likely to have lower IQ and achievement scores than others, and are more likely to repeat school grades than other children. When they grow up, they are more likely than others to become teenage parents themselves.

Unwed teenage mothers are more likely to complete their education, get decent jobs and avoid dependence on welfare if they live with their parents than if they live alone.

Infant Death Risk Twice as High for Teen Mothers as for Mothers in Their 20s

Data from New York State for 1974–1978 indicate that babies born to teenage mothers are far more likely to die in the first year of life than those born to mothers over age 20. Their risk of death is nearly two times greater than that of babies born to mothers in their 20s, and is greater than that of infants born to mothers aged 40 or older—a high-risk age-group.

Maternal mortality also appears to be higher among teenage mothers, especially young adolescent mothers: In 1977–1978, the maternal death rate among mothers under age 15 was 18 per 100,000 live births—two and one-half times the rate among mothers aged 20–24 (7.1). Nonfatal maternal complications were considerably lower in 1975–1978 than in 1961–1969 for all age-groups, but were still higher for teenage mothers than for others: Teenage mothers were 15 percent more likely to suffer from toxemia, 92 percent more likely to have anemia and 23 percent more likely to suffer from complications attendant upon a premature birth than were mothers who gave birth at ages 20–24.

The risks are much greater for those who are poor and black, but differentials by age at birth still persist.

Mothers 15 and Younger 2 Times More Likely to Have Low-Birth-Weight Babies

Teenage mothers are far more likely than those who delay childbearing until their 20s to have babies that are premature or of low birth weight (less than 5.5 pounds). Low birth weight is a major cause of infant mortality, as well as a host of serious childhood illnesses, birth injuries and neurological defects, including mental retardation.

Improved prenatal care has reduced prematurity and low-birth-weight rates among all age-groups, but mothers aged 15 and younger are still two times more likely to have low-birth-weight babies than are those aged 20–24. Among all teenagers, the risk is about 39 percent higher. The risk declines with increasing age of the young mother, but even mothers aged 19 have rates 27 percent higher than those who wait to give birth until they are in their early 20s. Low-birth-weight rates among black babies continue to be much higher than those among whites whatever the age of the mother, in part because black women obtain prenatal care much later.

Figure 24.
Number of infant deaths per 1,000 live births, by age of mother, New York State, 1974–1978

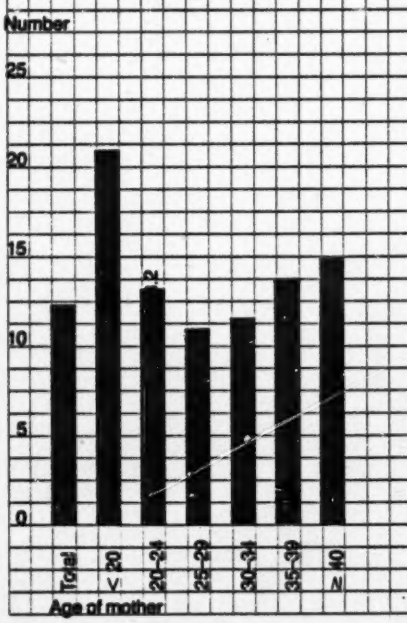
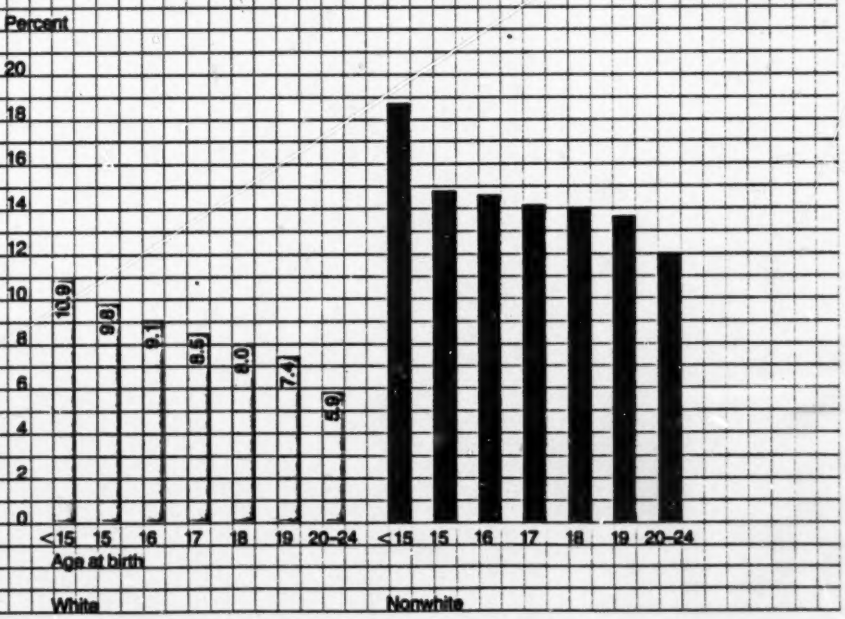


Figure 25.
Percentage of babies of low birth weight (less than 2,500 grams), by age of mother, according to race, 1978



Teen Childbearing Frustrates Educational Opportunities, Preparation for Careers

Many teenage parents finish high school; some even get to college. But the majority of them, especially of young teenage mothers, never obtain even a high school diploma.

The devastating effect of early childbearing on educational opportunity is not simply the result of poverty, low aptitude or lack of interest in learning. A national study matched samples of young people for race, socioeconomic status, academic aptitude and achievement and educational expectations at age 15. It found that among these matched samples, when reinterviewed at age 29, mothers who had given birth before they were 18 were only half as likely to have graduated from high school as those who postponed childbearing until after they turned 20.

For young fathers in the matched samples, the effect, as might be expected, was less dramatic, but still substantial: Those who became fathers before age 18 were two-fifths less likely to have graduated from high school than those who waited.

The net effect of childbearing at ages 18–19 on high school graduation is significant, but not nearly so great as childbearing at younger ages. It has a very large effect, however, on completing college. By age 29, women who delayed childbearing until their 20s were 4–5 times more likely to have completed college than those who became mothers in their teens. By age 29, young men who became fathers in their teens were only half as likely to have completed college as those who put off fatherhood until their early 20s.

Studies show that children of teenage parents also suffer educational and cognitive deficits: They tend to have lower IQ and achievement scores than the children of those who delayed childbearing, and are more likely to repeat at least one school grade.

Income of Young Teen Mothers Half That Of Those Who First Gave Birth in Their 20s

Teenage parents are more likely than those who delay childbearing to have low-status, low-paying jobs or to be unemployed. The mean family income in 1975 of white women who gave birth at or before age 16 was $7,550, about half of the $13,900 earned by families where the mother delayed birth until her middle-to-late 20s. The younger the mother at childbirth, the lower her annual family income.

Looked at in another way, 54 percent of 24-year-old women who had given birth at age 17 or younger were classified as being of low socioeconomic status, compared to 33 percent of those who had given birth between ages 21 and 23 and 15 percent of those still childless.

Poor education is one of the major factors keeping teenage mothers' incomes low. Another factor is the relatively high probability that teenage mothers will bring up their child in a home where there is no breadwinning father present.

Figure 26.
Percentages of mothers and fathers, in samples matched for race, socioeconomic status, academic aptitude, achievement and educational expectations at age 15, who received a high school diploma and completed college, by age of parent at birth of first child

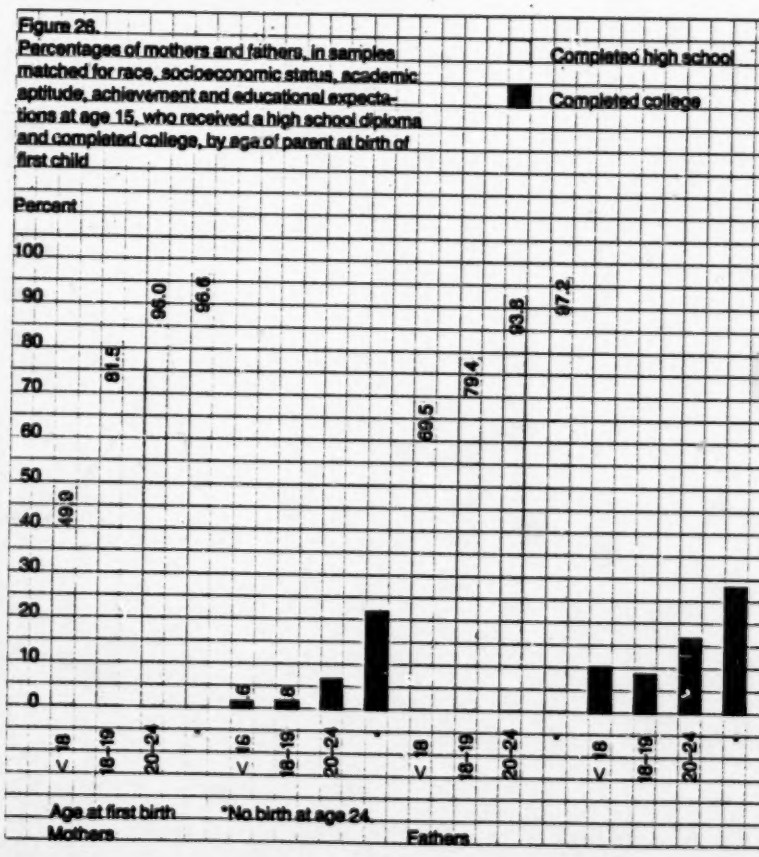
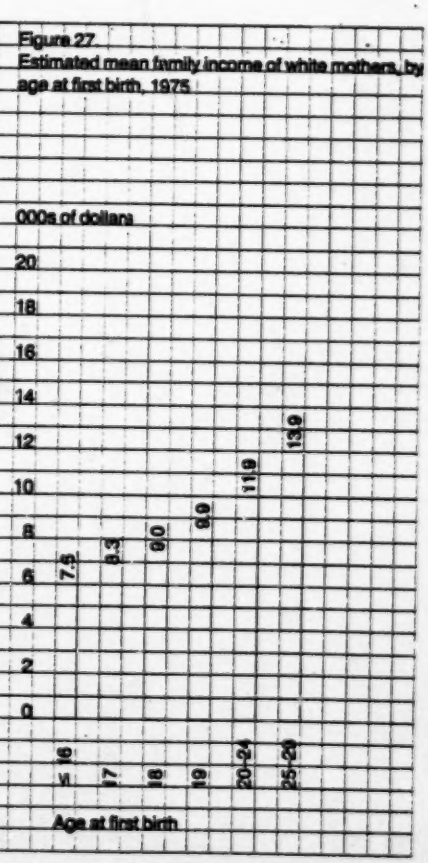


Figure 27.
Estimated mean family income of white mothers, by age at first birth, 1975



Marriage Disruption 3 Times More Likely For Young Teens Than Later Childbearers

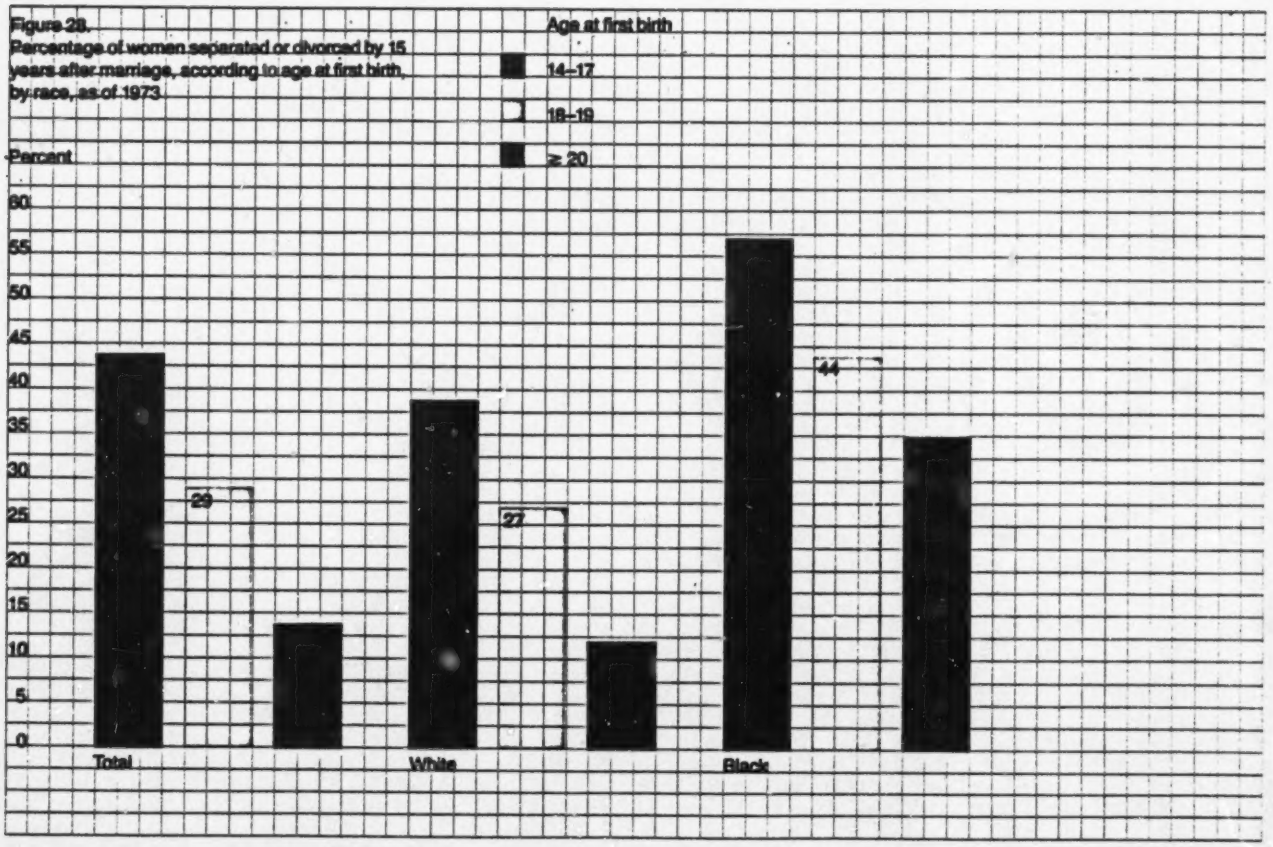
If they marry, teenage parents are far more likely to separate or divorce than couples who postpone childbearing until their 20s. The trend is evident among women of all races, but is more pronounced among whites than among blacks.

Forty-four percent of women who gave birth at ages 14–17 are separated or divorced within 15 years, three times the proportion among women who did not begin childbearing until age 20 or later. Marriage disruption is two times more likely among those who become parents at ages 18–19 than among those who wait until their 20s.

As a result of this pattern, by age eight, 70 percent of children first-born to women at age 17 or younger have spent part of their childhood in a single-parent household. This compares to 41 percent of the children first-born to women at ages 18–19, and about 25 percent of children first-born to women in their 20s.

Young mothers who do not live with the child's father are far less likely to receive child-support payments than are older mothers: More than one-quarter of all mothers who are not living with their child's father receive child-support payments, compared to only one in 10 such mothers aged 14–24. For the small number of young mothers who do receive financial help from the father, the support payments are generally small, averaging only $1,388 a year.

Figure 28.
Percentage of women separated or divorced by 15 years after marriage, according to age at first birth, by race, as of 1973



$4.7 Billion in AFDC Payments to Families Where Mother Gave Birth in Her Teens

Many teenage mothers with small children to take care of, few skills, little education and no husband in the home must become dependent on public welfare for support. In 1975, about half of the $9.4 billion invested in the federal Aid to Families with Dependent Children (AFDC) program went to families in which the woman had given birth as a teenager. Six out of 10 women in families receiving AFDC payments had given birth as teenagers, compared to just about one-third of women in families not receiving such payments.

About one-fourth of teenage mothers are currently receiving AFDC payments.

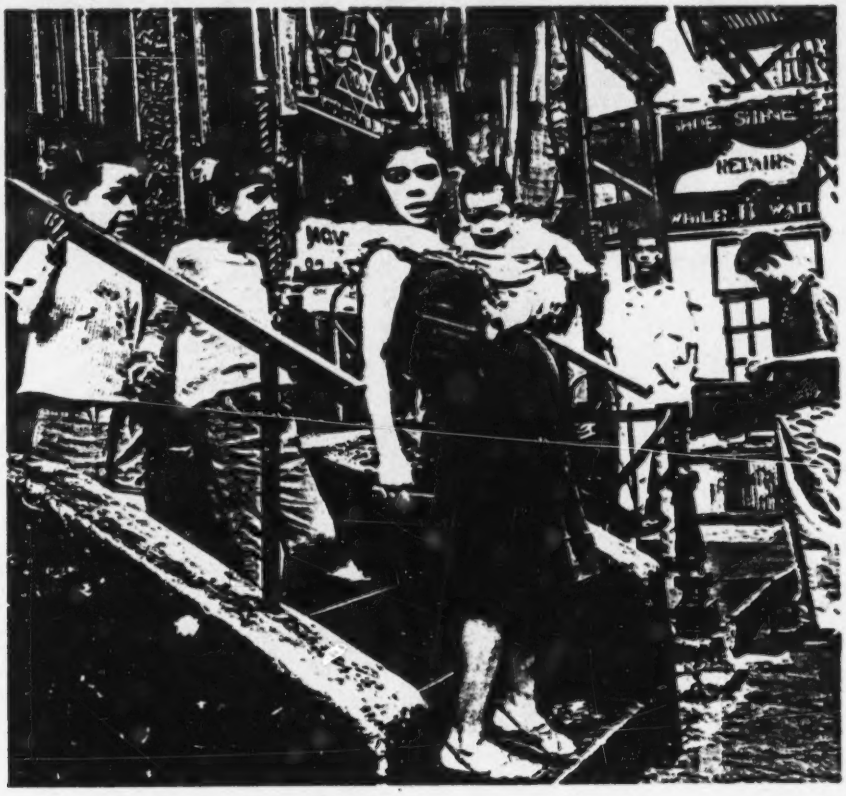
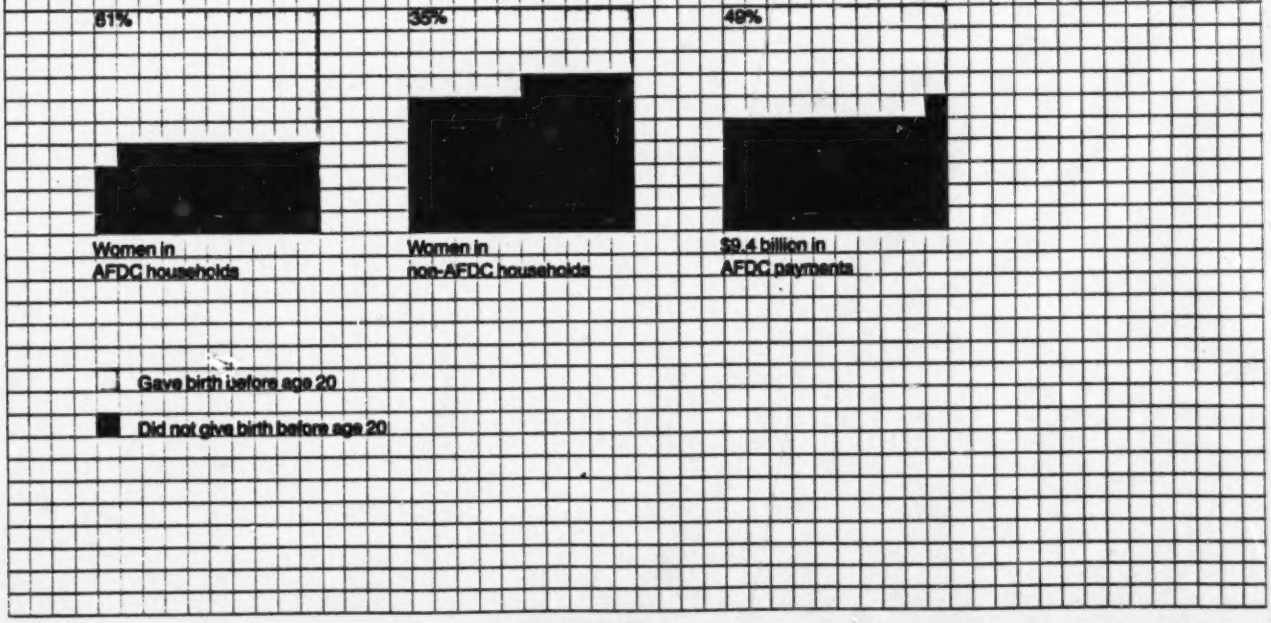


Figure 29.
Percentage distributions of women in AFDC households and non-AFDC households, by whether they gave birth before age 20, and percentage distribution of $9.4 billion in AFDC payments, by whether recipients gave birth before age 20, 1975

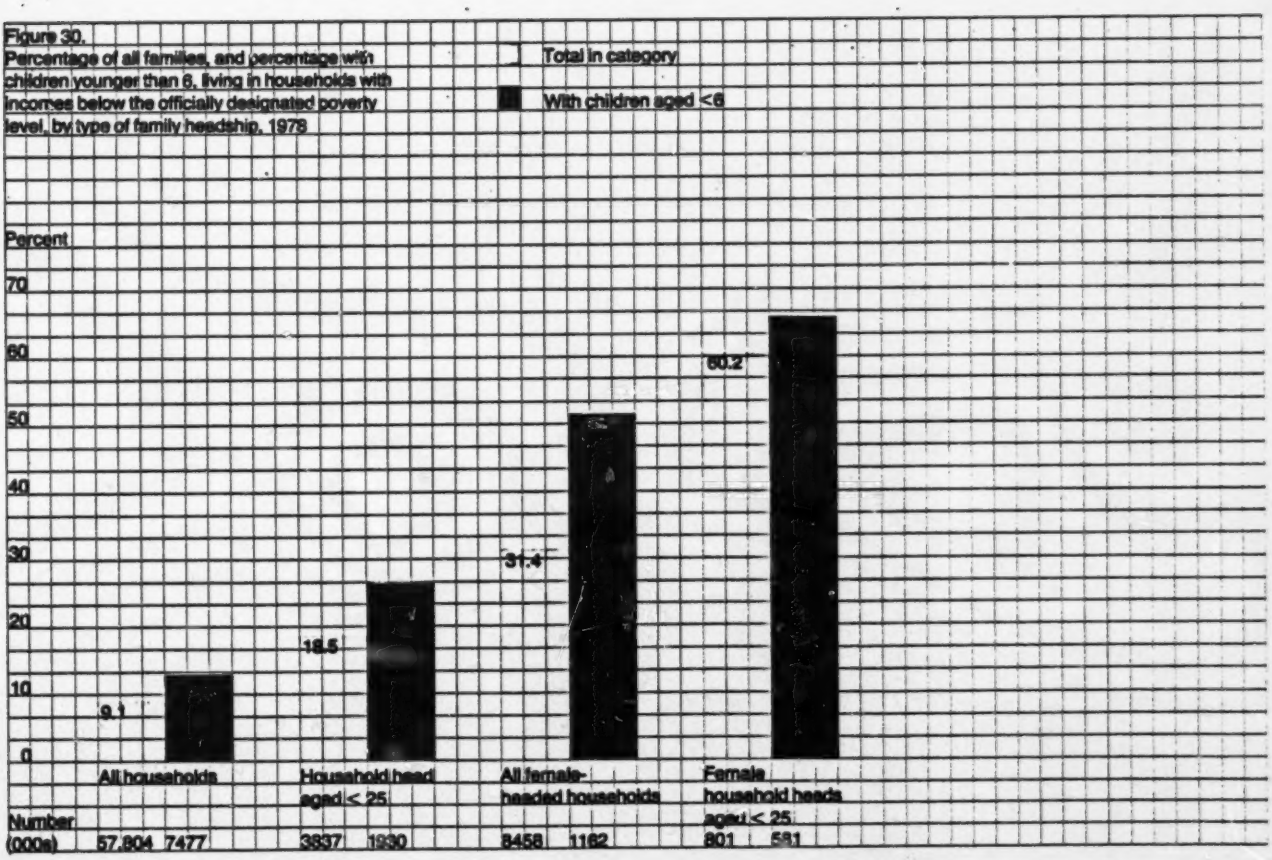


Families Headed by Young Mothers 7 Times as Likely as Others to Be Poor

There are nearly 600,000 families with children five years old or younger headed by mothers aged 14–25. Two-thirds of these families are living below the officially designated poverty level ($6,682 for a nonfarm family of four). This is five times the proportion of all families with such young children living in poverty (13 percent), and seven times the proportion of all families living in poverty (9 percent).

Indeed, the median annual income of families headed by women under age 25 is $3,953—well below the official poverty level. Such families have incomes only about one-fifth as high as that of all families and three-tenths as high as that of young husband-wife families.

Figure 30.
Percentage of all families, and percentage with children younger than 6, living in households with incomes below the officially designated poverty level, by type of family headship, 1978



Young Teenage Mothers Have 50% More Births Than Later Childbearers

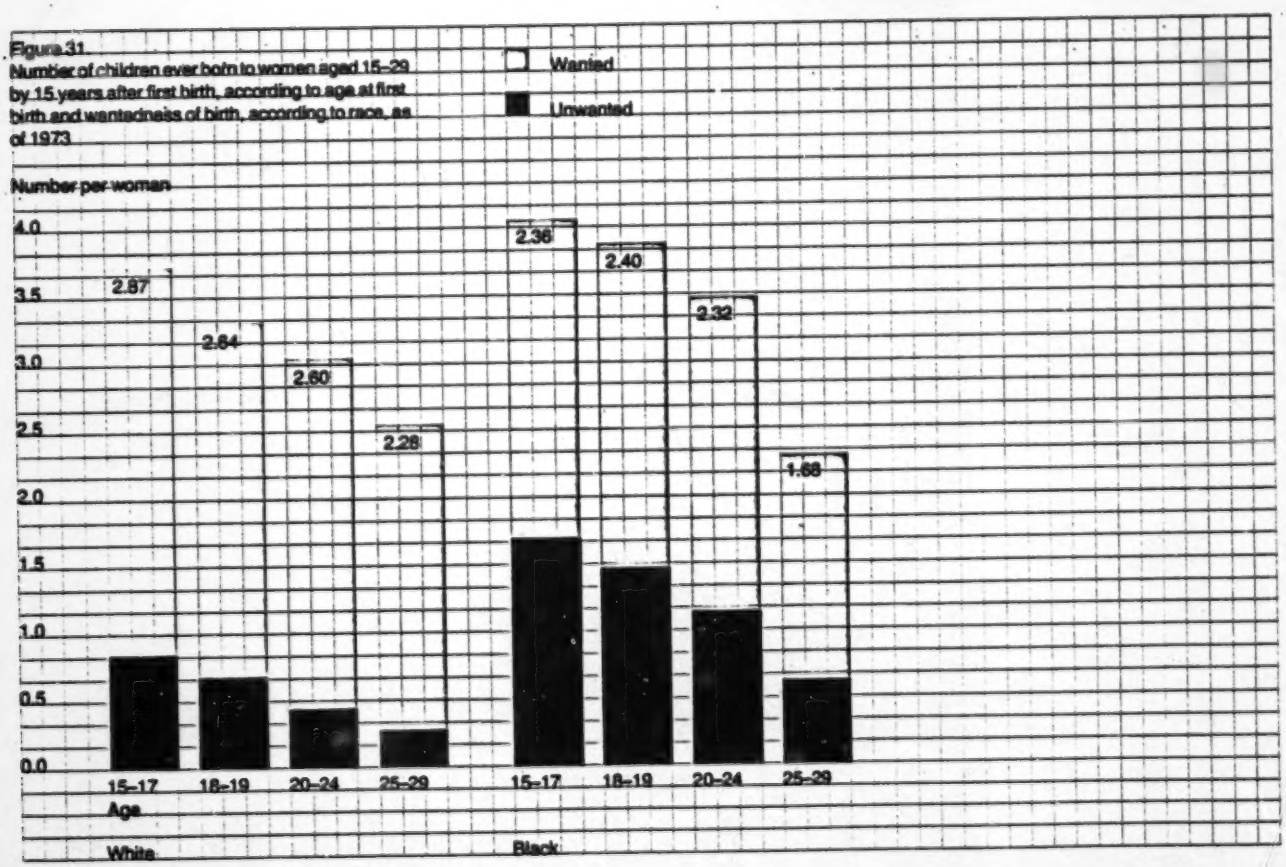
Women who gave birth as teenagers not only have lower incomes than other women, but generally have to stretch that income to feed more mouths.

White women who first gave birth at ages 15–17 have about 46 percent more children than those who waited to become parents until their middle-to-late 20s; those who gave birth at ages 18–19 have 30 percent more children.

Survey research also provides information about birth intentions. The number and proportion of all births that are unintended rise sharply with earlier age at childbearing—21–23 percent of all births to white women who became mothers as teenagers were unintended, compared to 10 percent of births to those who waited until their middle-to-late 20s.

The average mother who gave birth at ages 15–17 has had one unintended birth, while only one in four women who started childbearing at ages 25–29 has had an unintended birth. The same trends are seen among blacks as among whites, but the effects of early childbearing for total and unintended births are even more extensive for black women.

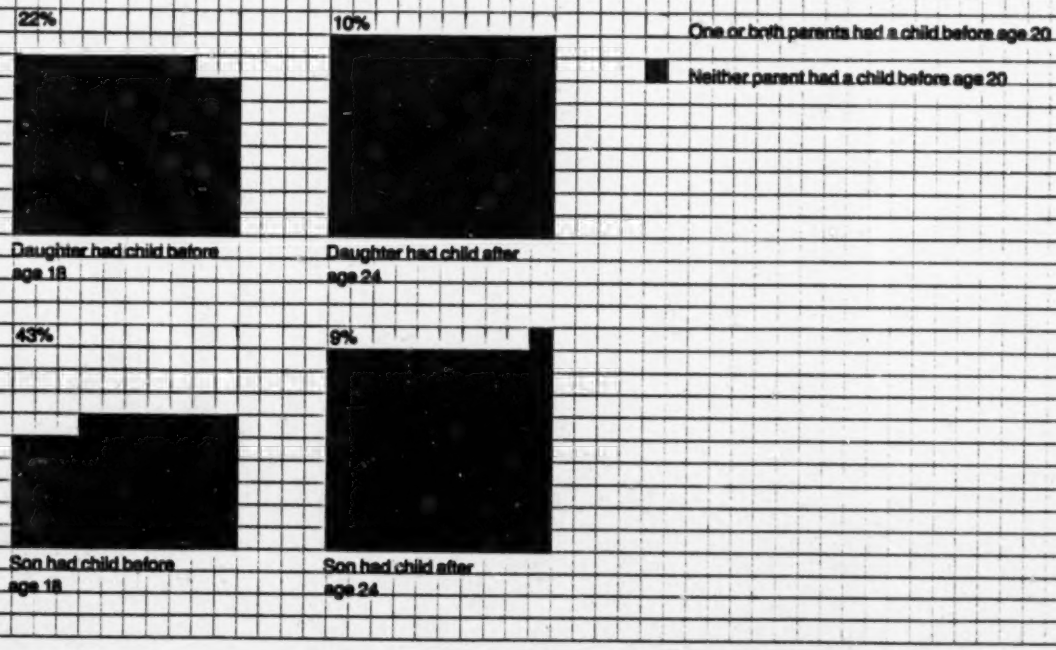
Figure 31
Number of children ever born to women aged 15–29 by 15 years after first birth, according to age at first birth and wantedness of birth, according to race, as of 1973



Teen Mothers More Likely to Have Had A Teen Parent Than Later Childbearers

Of those women who became mothers at age 17 or younger, 22 percent had at least one parent who had had a child as a teenager—more than two times the proportion of women who delay childbearing to age 25 or later. Forty-three percent of comparable young fathers had a teenage parent—nearly five times the proportion of young men who did not become parents before age 25. All in all, about 20 percent of teenage fathers and 15 percent of teenage mothers had a teenage parent—about half again the proportion of those who delayed parenthood until after age 20 (14 percent and 10 percent, respectively). The younger the mother at birth, the more likely she is to have had a teenage parent. In one study, 82 percent of girls who became mothers at age 15 or younger had mothers who first gave birth as teenagers.

Figure 32
Percentage distributions of women and men who first had a child before age 18 and who delayed childbearing to age 25 or older, according to age at which their parents first gave birth



SECTION 8

Abortion Services

For many teenagers who find themselves confronted with an unplanned pregnancy, abortion is preferable to an unintended birth. The number of abortions obtained by adolescents nearly doubled between 1973 and 1978. Poor and black teenagers were less likely to terminate an unwanted pregnancy by abortion than those who were white and more affluent. However, because unwanted pregnancies were much more prevalent among poor and black teens, their abortion rates were little different from those of the other groups. Increased availability of abortion has not resulted in a relaxation of contraceptive use among teenagers, but has been associated with an improvement in their contraceptive practice.

Because of distance, cost, parental consent requirements, lack of familiarity with the medical system, menstrual irregularities and psychological factors, teenagers are much more likely than older women to delay abortion to the later, more dangerous weeks of pregnancy.

Most U.S. counties have no abortion facilities, and cost has been an increasing obstacle to service since the Supreme Court declared the Hyde Amendment constitutional. (Most young people are dependent on their parents, partners or public funds to pay for their abortions.) Parental consent is required by two-fifths of abortion facilities for at least some teenage patients. Three in 10 teenagers estimated to want and need abortion services in 1978 were unable to obtain them, and their pregnancies resulted in unintended births. As is the case with contraception, most young teenage patients tell their parents about their decision to have an abortion, but a significant minority would not come to the facility if parental notification were required. Thousands of illegal or self-induced abortions and additional unintended births could be expected to result.

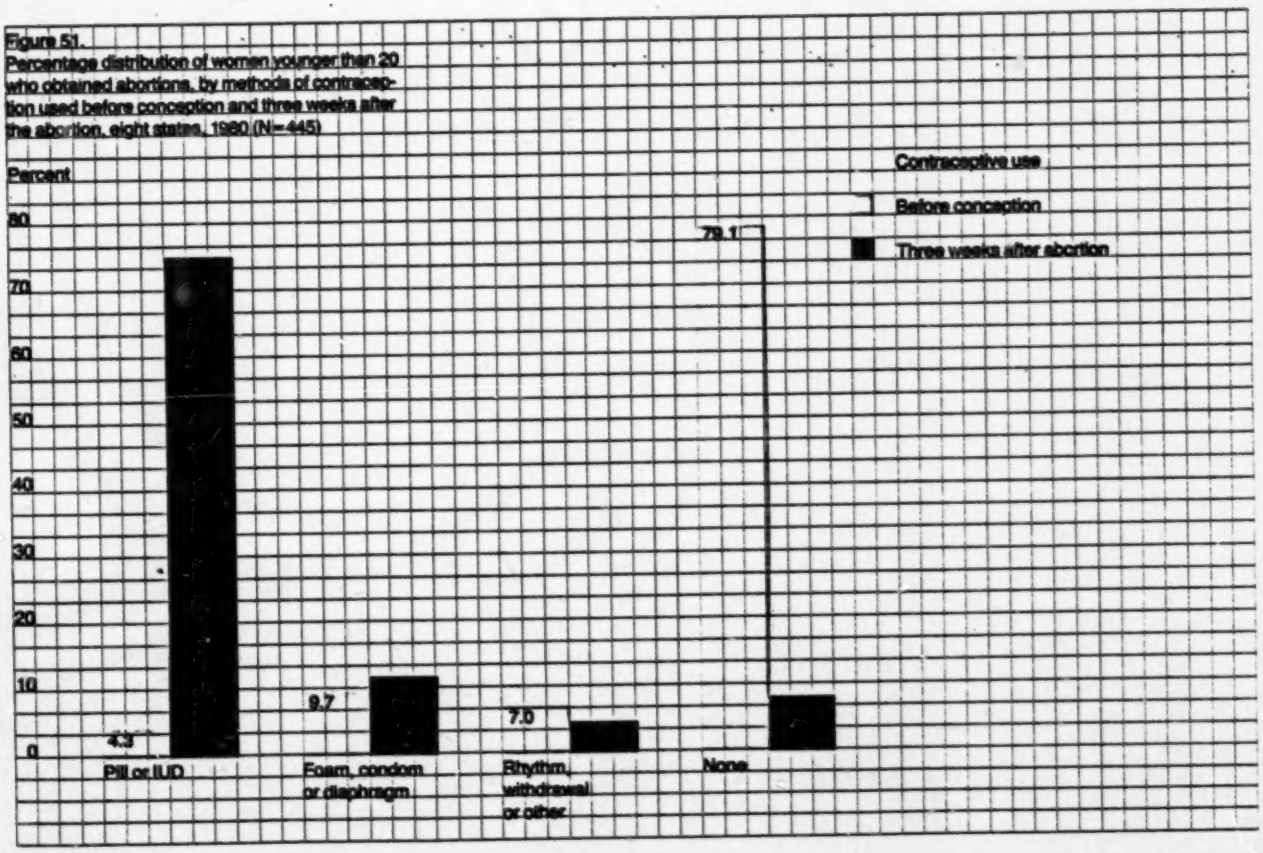
Abortion Availability Leads to Better, Not Poorer, Contraceptive Use by Teens

The availability of legal abortion has not resulted in a relaxation of contraceptive vigilance among teenagers. As we noted earlier, the pregnancy rate among sexually active adolescents has declined by 22 percent since abortion was legalized (see Figure 12) and contraceptive use has increased by 35 percent (see Figure 4).

Indeed, there is strong evidence that teenagers practice contraception much more effectively after they have had abortions than they had before. One study involving nine clinics in eight states showed that eight in ten teenagers coming to a clinic to obtain abortions had used no method of contraception prior to the procedure, and only four percent had used the IUD or the pill. Three weeks following the abortion, only nine percent were not using any method and 83 percent were using the pill or IUD.

The Johns Hopkins National Survey of Young Women found that teenagers whose first pregnancy ended in abortion were only half as likely to become pregnant a second time within the following year than those whose first pregnancy resulted in a live birth (see Figure 15).

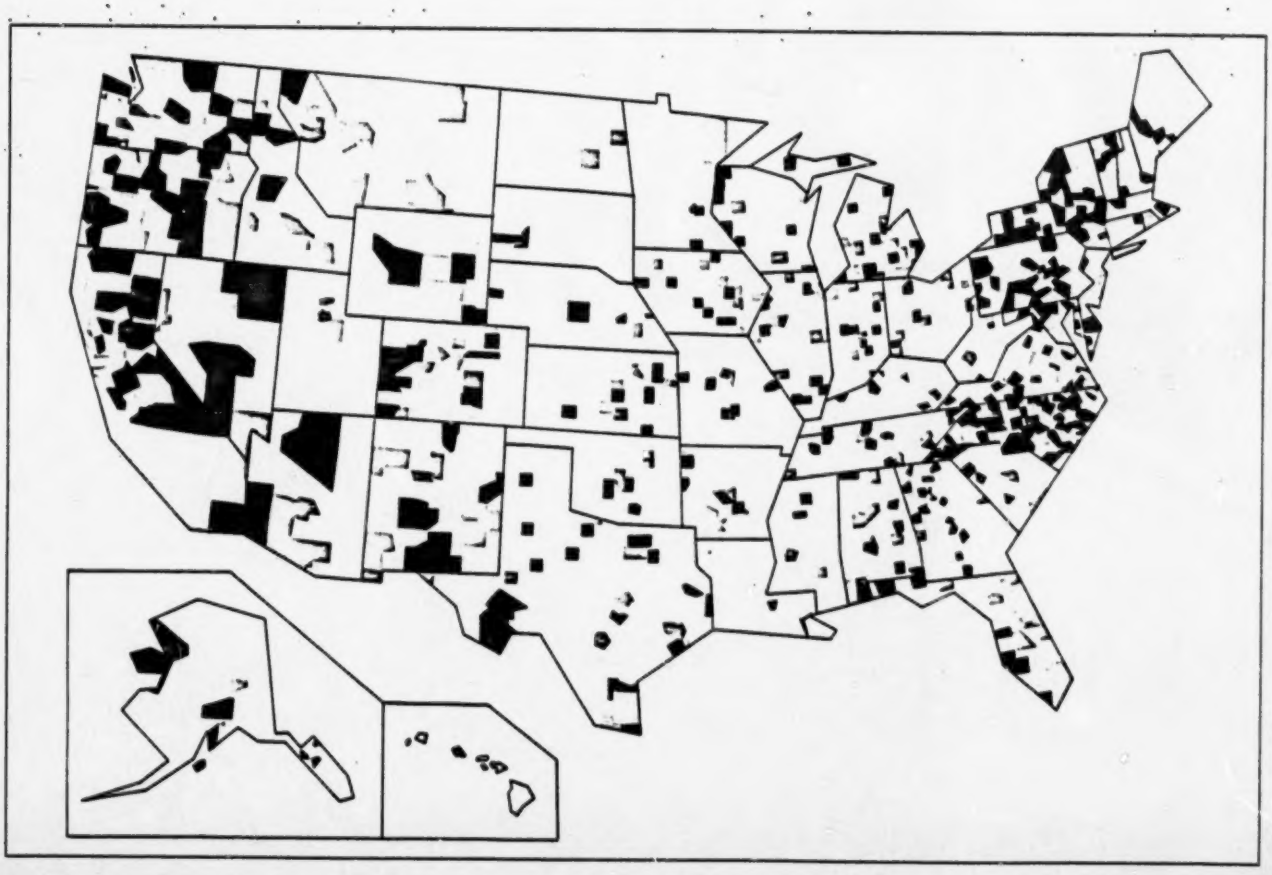
Figure 51.
Percentage distribution of women younger than 20 who obtained abortions, by methods of contraception used before conception and three weeks after the abortion, eight states, 1980 (N=445)



1/4 Million Teens in Need of Abortions Live in Areas Without Enough Facilities

Only 23 percent of U.S. counties have any facility providing abortions, and only 16 percent of counties have a facility providing as many as 30 abortions a year. Some 225,000 teenagers estimated to be in need of abortion services live in such unserved or poorly served counties. The need to travel to other, sometimes distant, communities to obtain abortions places a special burden on teenagers, who are often unable to afford the increased cost involved in travel and overnight stays, and are generally not familiar enough with the medical system to find out-of-town facilities that will serve their needs. Services are especially sparse in nonmetropolitan areas of the country. In Mississippi, the Dakotas and West Virginia, three-quarters of those in need of abortions live in counties that have no abortion facility.

Figure 52.
U.S. counties with at least one identified abortion provider, by number of abortions reported, 1978



*All abortions > 5 rounded to nearest 10.

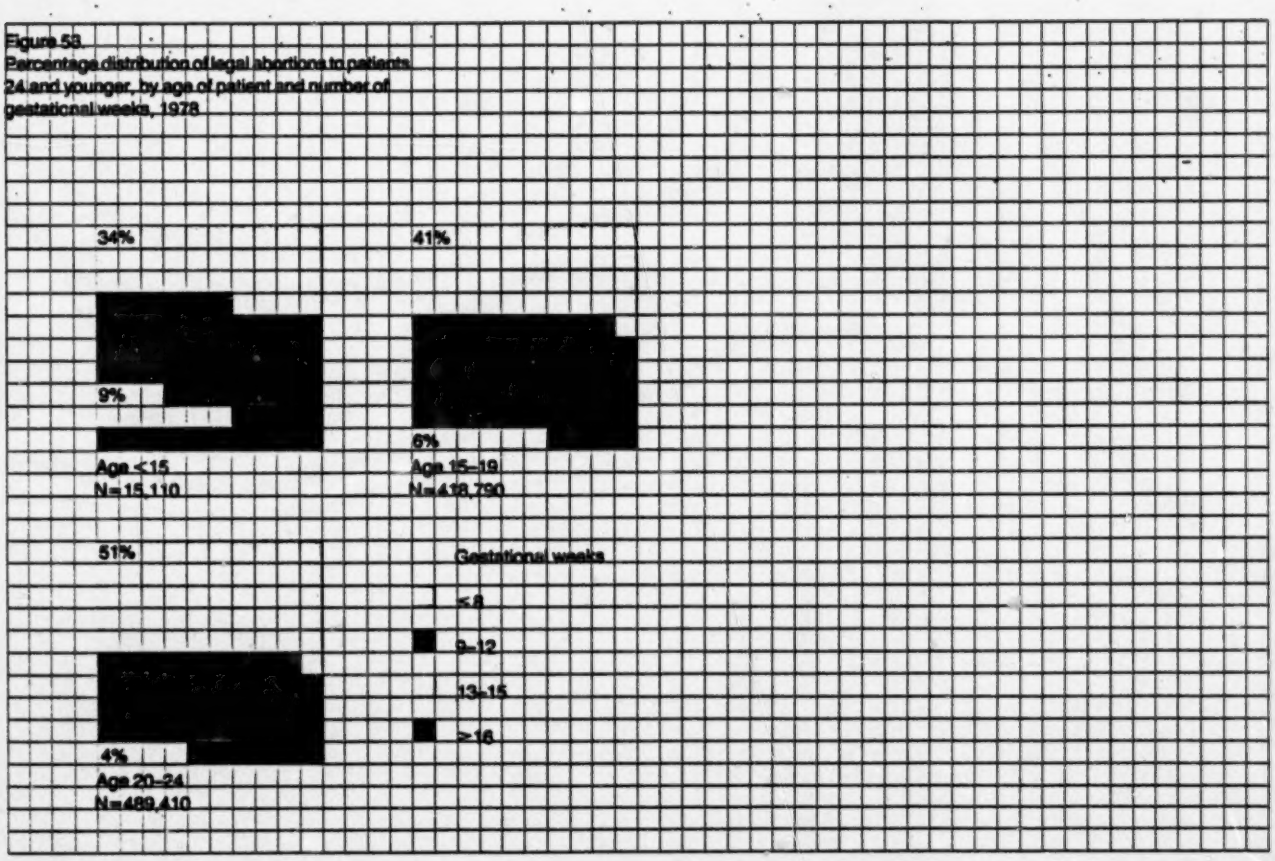
Teens More Likely to Delay Abortions To Later, Riskier Weeks of Gestation

Teenagers are less likely than women in their 20s to obtain abortions at the safer, earlier weeks of gestation. The younger the teenager, the more likely she is to have a delayed abortion. Thus, only 34 percent of abortions obtained by girls aged 15 and younger are performed at eight or fewer weeks' gestation, compared to 41 percent of abortions among 15–19-year-olds and 51 percent of those obtained by women aged 20–24. At the other extreme, 14 percent of abortions obtained by girls younger than 15 are performed at 16 weeks' gestation or later, compared to just seven percent of abortions among those aged 15–19 and four percent of abortions among women aged 20–24.

The risk of death and major complications from abortion rises with every week the procedure is delayed after the eighth week. Abortions that are delayed to the 16th week or later are as much as 13 times more dangerous than those performed at eight or fewer weeks.

Many factors have been cited as responsible for this delay, including difficulty of access because of geography (eight in 10 counties have no facility providing abortions). Fifty-five percent of teenagers who obtain abortions have to travel to other, often distant, counties to get them; such travel is usually more of a problem for teenagers than adults. Cost, an especially acute problem since the Hyde Amendment and its state counterparts cut off most public funding for abortions, also hinders access. Parental consent requirements, lack of familiarity with the medical system, irregular menstrual patterns and the psychological tendency of some young people to deny unpleasant truths are other factors that are believed to lead to delay.

Figure 53.
Percentage distribution of legal abortions to patients 24 and younger, by age of patient and number of gestational weeks, 1978

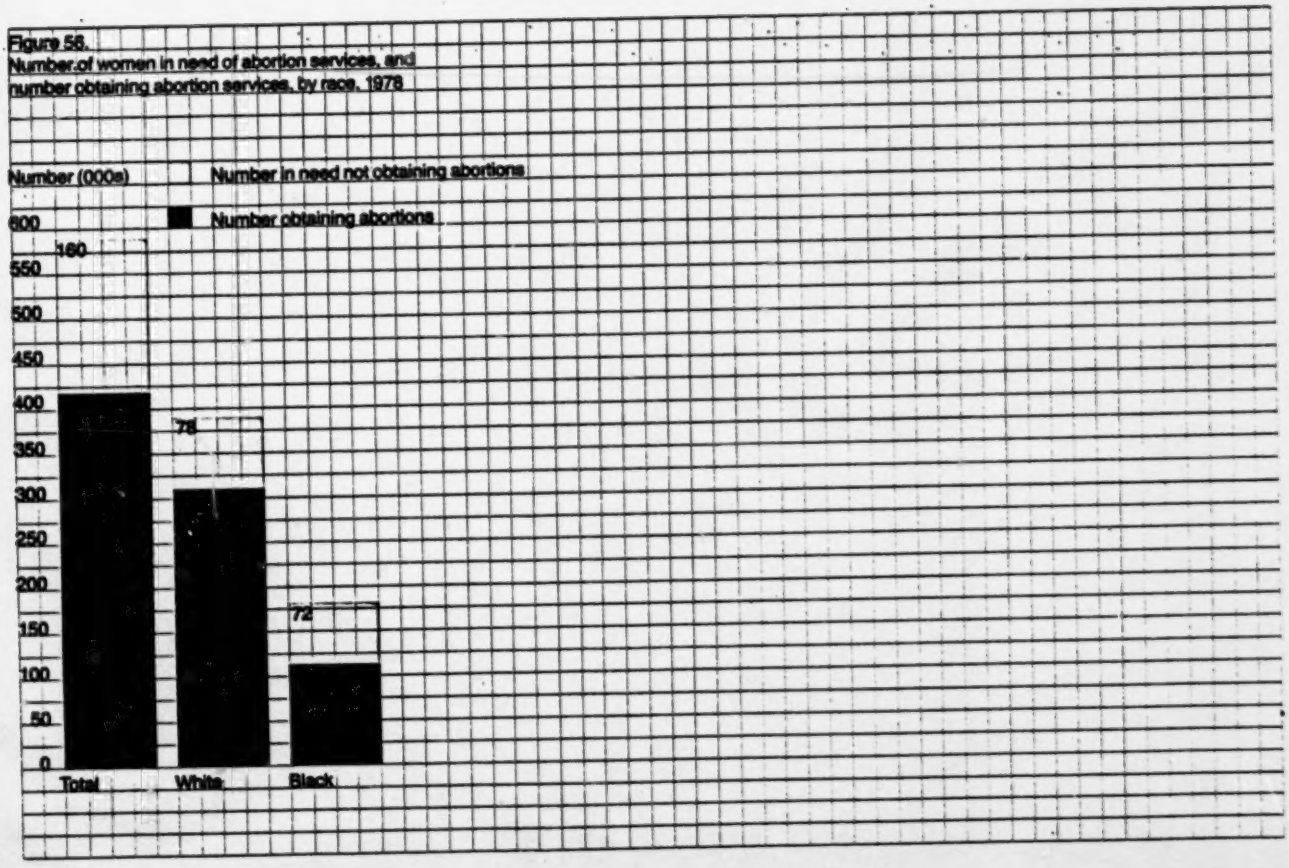


160,000 Teenagers Who Wanted Abortions In 1978 Were Unable to Obtain Them

It is estimated that if abortion services had been fully available and accessible in 1978, at least 579,000 women aged 15–19 would have obtained the procedure. About three in 10 of the teenagers estimated to want and need abortion services were unable to obtain abortions—a total of 160,000 teenagers who, as a result, had unintended births. These represent about six in 10 of all teenagers who had unintended births.

At least two in 10 white and four in 10 black teenagers in need of abortion services in 1978 were unable to obtain them.

Figure 58.
Number of women in need of abortion services, and number obtaining abortion services, by race, 1978



Document #15

JOURNAL OF ADOLESCENT HEALTH CARE 1:18–25, 1980

ORIGINAL ARTICLES

Adolescent Abortions in the United States

WILLARD CATES, JR., M.D., M.P.H.

Despite the fact that adolescent females have a more negative reaction to abortion than older women, they are apparently more likely to use legal abortion to prevent unplanned births. The most important variable affecting abortions among teenagers is the significantly later gestational age at which their procedures are performed. After adjusting for this factor, teenagers have generally lower morbidity and mortality rates from legally induced abortions than do older women. The scientific literature is inconclusive about whether present abortion methods will have any harmful effects on subsequent desired pregnancies. Current efforts to restrict abortion services for teenagers will probably produce a negative public health impact by encouraging delay in obtaining abortions after deciding to terminate a pregnancy.

KEY WORDS:
Abortion, legal
Abortion, morbidity
Abortion, mortality
Teenage pregnancy

The problem of pregnancy among teenagers has received considerable public attention. On one hand, births to teenagers are down (1) and contraceptive use among teenagers is up (2). On the other hand, the total number of pregnancies to teenagers has grown, as has the total number of abortions to teenagers (Figure 1). In 1977, the latest year for which data are available, teenagers accounted for over 400,000 induced abortions and approximately 1.2 million pregnancies; another 220,000 women conceived at age 19 years and completed their pregnancies at age 20 years. (3). At the current rates, up to 40% of today's 14-year-olds will be pregnant once before they are 20 (3).

Most officials concerned with the problems of teenage pregnancy prefer a primary prevention program, namely, avoiding unplanned pregnancies rather than unplanned births. However, this article discusses the less desirable issue of secondary prevention, namely, the means of preventing these unplanned births after the unplanned pregnancy occurs. This involves the often difficult choice, especially for a teenager, between terminating and continuing her pregnancy. The focus is on the attitudes toward and utilization of abortion by teenagers, the risks of abortion relative to those of other alternatives for teenagers, the public health impact of the increasing availability of abortion for teenagers, and finally the current threats to abortion services for pregnant teenagers.

Attitudes and Utilization

Attitude surveys have generally shown that American teenagers are less likely than women in their middle reproductive years to approve of abortion; moreover, younger teens are more negative than older teens about abortion (4). Most teenagers respond to questions about abortion, as about other issues, in moral absolute terms (5). Those who are opposed to abortion tend to view pregnancy termination as murder or feel the unplanned pregnancy is a just consequence of engaging in sexual activity. Those who favor a woman's right to choose abortion see the social and familial consequences of unplanned pregnancy as wrong.

While attitude surveys indicate teenagers, more than older women, disapprove of abortion, a disproportionate number of abortions is obtained by teenagers (Figure 2). Although teenagers form about 17% of the population of childbearing women, since 1972 they have accounted for about

From the U.S. Department of Health, Education, and Welfare Public Health Service, Center for Disease Control, Bureau of Epidemiology, Family Planning Evaluation Division, Atlanta, Georgia.
Direct represent requests to: Willard Cates, Jr., M.D., M.P.H., Center for Disease Control, Atlanta, GA 30333.
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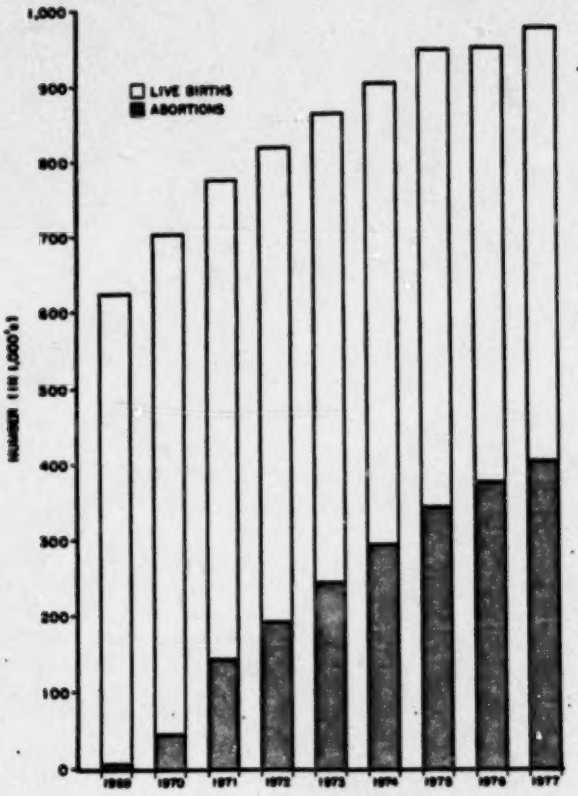

Figure 1. *Live births and abortions to teenagers in the United States, 1969–1977.*

33% of all abortions (6). The remarkable stability of the percentage of abortions for teenagers may indicate that, compared with older women, teenagers are not having an increased proportion of unplanned pregnancies. In 1977, the percentage fell slightly (see Figure 2), but this change may reflect a reporting artifact (6). Alternatively, it may reflect the fact that there were fewer teenagers at risk of pregnancy in 1977 than before (7).

The percentage of abortions to teenagers rose with each year of age through 18 (Table 1), a trend that parallels that of teenage sexual activity (2). Forty-four percent of all abortions to teenagers were obtained by women ≤ 17 years old, although this estimate is probably low. The apparent "clustering" of abortions at age 18 may result from younger women's reporting an age of legal adulthood in order to avoid being considered a minor.

Teenagers have higher abortion ratios (abortions/live births) than older women, except for women aged 40 years or older (Figure 3). Abortion

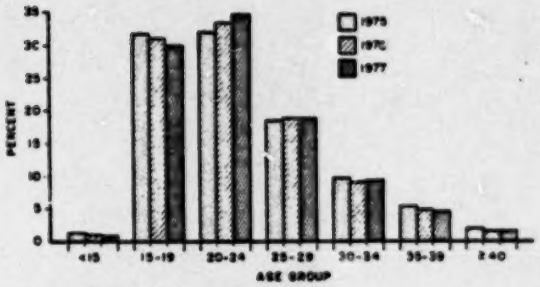

Figure 2. *Percent distribution (based on total number with age known) of reported legal abortions, by age, in all states with data available for 1975 (34 states), 1976 (36 states), and 1977 (37 states). (From Table 6 of 1975, 1976, and 1977 Abortion Surveillance Reports.)*

ratios appear to provide a good indicator of the percentage of unplanned pregnancies. Since 1975, women ≤ 14 years old have been more likely to terminate pregnancies through abortion than through a live birth. As teenagers get older, their abortion ratios generally fall (Table 1), implying that an increasing percentage of their pregnancies are planned and therefore continued to term. The elevated abortion ratio for 18-year-olds probably indicates the same overreporting tendency mentioned above.

Race is a much less important factor for teenagers than for older women in the decision either to terminate or to continue a pregnancy (8–10). The proportion of abortions obtained by whites or by blacks and other nonwhite teenagers is similar to that obtained by older women of the same races (Table 2). Between 1972 and 1974, black women accounted for approximately 25% of abortions for both teenagers and older women (6). This percentage has probably risen in the past 3 years, since the overall percentage of abortions to women of black

Table 1. Reported Legal Abortions Obtained by Teenagers, Percent Distribution, and Abortion Ratio: United States, 1977

Age (years)	Percent distribution		Abortion ratio*
	Separate	Cumulative	
13	0.7	0.7	1070
14	3.1	3.8	
15	7.2	11.0	718
16	13.8	24.8	612
17	19.1	43.9	529
18	28.5	72.4	581
19	27.6	100.0	457

Source: Center for Disease Control. Abortion Surveillance, 1977. Issued September, 1979

*Abortions per 1000 live births.

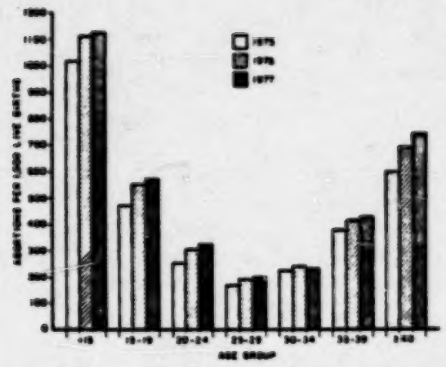

Figure 3. *Legal abortions, by age, in the United States, 1975–1977. Ratios are based on percent distribution shown in Figure 2 applied to total legal abortions reported to the Center for Disease Control, 1975–1977, and total U.S. live births by age of mother, 1975–1977, from Monthly Vital Statistics Reports, National Center for Health Statistics.*

and other nonwhite races has risen. However, data from states reporting age and race variables indicate that the relative proportions have not changed.

Teenagers have consistently waited until later in their pregnancy than older women to have their abortions (11). Nearly half of all abortions performed after 12 weeks of pregnancy are in teenagers (12). Adolescents were twice as likely as older women to obtain abortions after 12 weeks (Table 2). Moreover, the teenager's tendency to delay abortion is exaggerated at the later gestational ages; teenagers have 70% more abortions than do older women at 13–15 weeks of pregnancy but 100% more abortions at ≥ 16 weeks. The age of the teenager also influences the stage of gestation at which she obtains her abortion. Younger teenagers are even more likely to have later abortions than

Table 2. Estimated Percent Distribution of Legal Abortions Obtained by Teenagers, by Race and Gestational Age

	Years of age	
	≤ 19	≥ 20
Race		
White	72.9	73.5
Black and other	27.1	26.5
Weeks gestation		
≤ 8	33.7	44.8
9–12	47.7	44.3
13–15	7.3	4.4
≥ 16	11.3	5.5

Sources: Tietze C: Legal abortions in the United States: Rates and ratios by race and age, 1972–1974. Fam Plann Perspect 9:12–15, 1977; Cates W Jr, Tietze C: Standardized mortality rates associated with legal abortion: United States, 1972–1975. Fam Plann Perspect 10:109–112, 1978

are older teenagers; in states with data available in 1977, 23% of all abortions to females ≤ 14 years of age were beyond 12 weeks, vs. 12% to women 15–19 years and 8% to women ≥ 20 years. Because gestational age is the most important determinant of abortion complications (13), this tendency for teenagers to delay has the largest single effect on the risk to teenagers for complications and death from abortions.

In general, the data indicate multiple causes of delay even for the same pregnancy (11). Factors involving circumstances that the pregnant teenager can control include: ignorance of the signs of pregnancy until it is physically obvious; psychological denial of the pregnancy; ambivalence about the desirability of giving birth to a child; ambivalence about abortion relative to other options such as giving the baby up for adoption; pressure from influential people to have the child; lack of information on the availability of abortion; embarrassment about pregnancy; fear of pain or side effects after abortion; and lack of money. Other factors outside the control of the pregnant teenager may also lead to delay: lack of local abortion facilities; administrative requirements causing delay in processing applications; legal requirements for parental notification or approval; physician or hospital resistance to abortion for teenagers; incorrect diagnosis of pregnancy because of a false-negative pregnancy test or failure to perform a pelvic examination; and incorrect estimation of length of gestation by clinicians.

Although many of these factors can be eliminated through health education programs, sophisticated analyses document that a large proportion of delay is related to individually oriented factors (14). This idiosyncratic etiology strongly implies that the problem of delayed abortions, especially those for teenagers, will not be significantly influenced by public health interventions. Thus, continued efforts are needed to make late abortion procedures safer, cheaper, more readily available, and more acceptable to the women undergoing them.

Risks of Abortion for Teenagers

While many factors influence whether the pregnant teenager terminates or continues her pregnancy, the risks of morbidity and mortality are important considerations. Although our data from the CDC show that abortion, like any other surgical procedure, involves some risk, it also shows that the risk of complications or death for teenagers is no greater than that for older women (Table 3).

Table 3. Short-term Complication Rates and Death-to-Case Rates for Legal Abortion, by Age and Abortion Method

Age (years)	Complication rates[a]		Death-to-case rates[b]
	Suction curettage	Saline instillation	
≤ 17	0.3	1.4	1.8
18–19	0.4	1.4	
20–24	0.3	1.9	4.0
25–29	0.4	2.2	3.1
≥ 30	0.4	3.3	5.1

Sources: Joint Program for the Study of Abortion/CDC, unpublished data; Cates W Jr, Tietze C: Standardized mortality rates associated with legal abortion: United States, 1972–1975. Fam Plann Perspect 10:109–112, 1978

[a]Major complications per 100 procedures.
[b]Deaths per 100,000 abortions.

Short-Term Morbidity

For suction curettage procedures performed at ≤ 12 weeks of gestation, teenagers and older women have a similar risk of short-term major complications (see Table 3). With saline instillation procedures, however, age is an important factor influencing the risks (see Table 3). Major complication rates were lower for teenagers than for any other age group, and complication rates rise with age. Women over 30 were 2.3 times more likely than teenagers to suffer major complications with saline. The same trend toward lower complication rates for teenagers generally held for two other procedures performed after 12 weeks—dilatation and evacuation and prostaglandin $F_{2\alpha}$ instillation; however, the numbers are so small that there is some overlap of complication rates among the different age groups.

Mortality

Teenagers have a lower death-to-case rate than older women after a legally induced abortion (see Table 3). Our data demonstrate that in the period 1972–1975, the crude death-to-case rate for teenagers was 2.2 deaths per 100,000 procedures (12). However, because teenagers obtain their abortions later in pregnancy than do older women, these comparative rates must be standardized for gestational age. After this adjustment is made, the death-to-case rate for teenagers is reduced to 1.8 per 100,000 procedures. Most recently, this rate has been even lower since the overall risk of dying from induced abortion declined markedly in 1976 and 1977 (6).

While teenagers have lower death-to-case rates than do older women from legally induced abortion, they also have lower risks of dying from complications of pregnancy, childbirth, and the puerperium. To compare the relative risks for teenagers of terminating vs. continuing pregnancy, we contrasted the standardized death-to-case rates for legally induced abortion with the standardized rates for death from other pregnancy-related causes (12), excluding abortion and ectopic pregnancy. We adjusted the birth-related fatality rate for teenagers by using the same age and race distributions we used in standardizing abortion-related mortality. In the period 1972–1975, teenagers who continued their pregnancies had a standardized death-to-case rate of 9.5 deaths per 100,000 live births; as noted above, the standardized death-to-case rate for legally induced abortions was 1.8 per 100,000 procedures. Thus, the risk that a teenager would die from pregnancy continuation was fivefold higher than that from pregnancy termination.

The increased risk of maternal mortality for teenagers may partly reflect their tendency not to obtain adequate prenatal care (15); yet, this factor alone would be unlikely to account for the fivefold risk associated with pregnancy continuation. Moreover, the data presented above have several limitations which suggest that a fivefold risk may be a minimum estimate: (a) Birth-related mortality rates using this analysis were based only on deaths attributed to complications of pregnancy, childbirth, and the puerperium, and not on delivery-associated deaths attributed to other causes such as cardiovascular disease. Such associated deaths are included in abortion-related deaths. (b) Data on abortion deaths of teenagers include 4 cases of planned pregnancies that were terminated for medical indications. Thus, the abortion group included some of the highest risk patients whose abortions were performed because the pregnancy was life threatening. Thus, the comparison undercounts pregnancy-related deaths relative to abortion-related deaths of teenagers.

Between 1972 and 1978, 29 teenage women died after legally induced abortion. The causes of these deaths to teenagers were slightly different than those of older women who died after legal abortions. Teenagers were more likely to die from infection but less likely to die from hemorrhage. Twelve (41%) teenage women died from infection, usually related to unrecognized retained products of conception after a uterine evacuation procedure. In 9 of these 12 cases, the teenage woman delayed seeking treatment of postabortion symptoms

suggesting infection, possibly because of their reluctance to let their parents know that they had had an abortion procedure. Preventive approaches could emphasize both counseling teenagers about the need to act as soon as possible if they suspect any complications, and providing treatment facilities that will be able to respond immediately to any complications in a confidential manner without involving the parents.

Only 1 (3%) teenage woman died from hemorrhage, less than the 15% of older women who died from this cause. Although the numbers are small, we can speculate that teenagers may have a greater hematologic reserve to sustain them through an acute episode of blood loss and hypovolemia. Seven (24%) teenage women died from embolic events, including 3 from suspected amniotic fluid emboli after saline or prostaglandin instillation procedures, 2 from pulmonary thromboemboli, and 2 from air emboli.

Fifteen teenagers died after illegally induced abortions between 1972 and 1978, accounting for 18% of the 82 illegal abortion deaths that occurred during this interval. Because illegal abortion is a clandestine event, no accurate denominators are available to calculate death-to-case rates for teenagers compared with older women. However, the proportion of teenagers who died after illegally induced abortion is similar to the proportion of teenagers (21%) who died after legally induced procedures during these same years. If these numerators are accurate reflections of the denominators, this indicates that teenagers are no more likely than older women to be using illegally induced abortion since 1972.

Emotional Complications

Very few teenagers have severe psychiatric complications after induced abortion; most are relieved to have terminated an unplanned pregnancy (16). Studies have shown, however, that teenagers are at higher risk than older women of suffering short-term psychological sequelae after induced abortion (16). Relatively more teenagers than older women suffered anxiety, depression, sadness, guilt, and regret. The most important factor affecting a woman's reaction to her abortion was the level of support provided by influential others including parents, partners, and peer group. The psychological reaction to abortion was significantly more favorable when parents and partners were supportive.

The type of abortion procedure also affects the psychological sequelae; uterine curettage procedures are associated with more favorable postabortion reactions than are labor-like instillation procedures (17). Because teenagers are more likely to delay abortion until the later gestational ages when instillation procedures may be used, clinicians should be aware of the emotional impact of the particular method they use.

Although teenagers have a higher rate of emotional complications after abortion than older women, younger women also have a higher rate of psychiatric complications after term birth. In England, the frequency of postpartum depression was highest for younger women (18). Although rates were not stratified by age, another study in England showed a threefold higher rate of postpartum depression for women whose planned pregnancies went to term than the rate for women who terminated their pregnancies by induced abortion (19). Thus, teens who continue unplanned pregnancies to term appear to be at even higher risks of psychological sequelae than if they terminated their pregnancies.

Long-Term Effects

Perhaps of greater concern to pregnant teenagers is whether induced abortion will threaten later desired pregnancies. Because many teenagers may eventually wish to bear children, they should naturally be accurately informed of any known long-term risks of terminating pregnancy. However, studies of late complications after induced abortion have produced conflicting results and make the subject of long-term sequelae an unresolved issue (20).

Recent data implicate three factors influencing whether an induced abortion will affect future pregnancies: (a) the abortion procedure used, (b) the patient's gravidity, and (c) the number of induced abortions they have already had. In regard to various abortion procedures, the wider the caliber of dilatation, the wider the cervical os 6 weeks later (21); sharp curettage procedures frequently require wider dilatation and have been associated with increased risks of midtrimester spontaneous abortion and low birth weight in subsequent pregnancies (22,23). However, suction curettage procedures are not apparently associated with a significantly increased risk of adverse outcome in subsequent pregnancies.

Women who terminated their first pregnancy by induced abortion were at higher risk for later second-trimester spontaneous abortion (23). The rates of second-trimester spontaneous abortion were also higher for women who had more than one pregnancy terminated by induced abortion (23). In England, women who were < 15 years old at the time of their abortion had more adverse events associated with later pregnancies than did older women who had abortions, perhaps because there was greater trauma to the younger women's smaller, tighter cervixes or because wider dilatation was necessary because of their later average gestational age (24).

Although the issue is unresolved, several clinical recommendations can be made for teenagers in order to reduce the possible risks of late sequelae after legally induced abortion. First, teenagers considering pregnancy termination should be encouraged to decide as soon as possible in order to reduce both the short-term and the possible long-term risks from abortion or allow proper prenatal care early in pregnancy. Second, if a nulliparous teenager with a small cervix requests an abortion that would require dilatation of > 11 mm, the use of laminaria tents should be seriously considered. Third, teenagers who have had one other induced abortion and plan to have a child in the future might stress the effectiveness of a contraceptive method more than its safety.

Public Health Impact of Teenage Abortion

The availability of legal abortion for teenagers has had an impact on four public health parameters: mortality, fertility, contraceptive usage, and marriage patterns for teenagers. The total number of teenage abortion-related deaths (including those from spontaneous abortions as well as legally and illegally induced procedures) has declined markedly since legally induced abortion has been more readily available (25). This pattern probably means that many teenagers are now choosing to terminate unplanned or unwanted pregnancies through safer legal channels rather than resorting to the less safe, self-induced or nonphysician-induced procedures.

Legalization of abortion has been temporally associated with a decline in out-of-wedlock birth rates in New York City (26), California (27), Oregon (28), and the United States as a whole (29). Because a large proportion of teenage out-of-wedlock births were unwanted, and because more than 85% of abortions to teenagers have been to unmarried women, some increase in the number of abortions to teenagers probably affected unintended fertility. State-to-state variation in teenage childbearing shows a significant correlation with their abortion/live birth ratio (30). This also indicates that legal abortion is used by many women to limit their unintended births.

The increasing utilization of legally induced abortion by teenagers has been alleged by some to cause a decrease in their use of contraception. However, at least four different approaches have demonstrated the opposite, namely, that there has been an increasing use of contraception during the era of the increasing availability of legal abortion:

First, case series reports have documented that teenagers obtaining abortions were more likely to be using effective forms of contraception 6 months after their procedure than they were before their unplanned pregnancy (31,32).

Second, the national patterns of increasing sexual activity among teenagers contrasted to the declining birth rates among the same group indicate that teenagers are becoming increasingly able to control their fertility through either contraceptive practices or abortion. The proportion of never-married 15–19-year-olds having unprotected intercourse decreased by one-third between 1971 and 1976 (2). Moreover, in 1976, almost one-third of the sexually active teenagers were using oral contraceptives, twice the proportion of 1971; the increase was more dramatic for 15–17-year-olds than for older teens (2).

Third, between 1960 and 1974, the conception rates actually decreased between an estimated 4–36%, depending on the assumption about the number of illegal abortions performed in the earlier years (33). This decline is consistent with increasing contraceptive use to prevent conceptions.

Fourth, although a substantial majority of young unmarried women who became pregnant and had an abortion were not contracepting, they were no less likely, and were probably more likely, to be contracepting than young women who unintentionally became pregnant and did not have an abortion (34).

Thus, the evidence to date suggests that the availability of legally induced abortion is associated with an increasing use of contraception by teenagers, compared with the era when legal abortion was not widely available.

However, providing contraceptive services for teens will not eliminate the need for abortion. Even intensive service programs emphasizing contraception that are directed at young women have required abortion to prevent unintended births. For example, despite a 1972 law in Georgia allowing minors to consent for their own contraception, it was not until abortion was readily available that the decline in births in Georgia teenagers 14 years or younger was observed (35). This decline first occurred in the same geographic area where the abortion facilities were most accessible and where abortion utilization was the highest. Moreover, in New Haven, Connecticut, a high proportion of young women who participated in a comprehensive pregnancy-care service for school age mothers had a second unplanned pregnancy which they terminated through legally induced abortion (36). Without the availability of legal abortion, these women would have had to choose between illegal abortion and a second unplanned birth.

The availability of legal abortion has also affected teenage marriage rates. In the United States, before 1969, trends in crude marriage rates among states with different levels of legal abortion services were similar. Beginning in 1970, especially among teenagers, states with a high legal abortion/live birth ratio began exhibiting significant declines in crude marriage rates that were not experienced by states with relatively low ratios (37). This suggests that liberalized abortion policies might be providing teenagers with a new alternative to marriage forced by premarital pregnancies, and therefore be related to the decline in marriage rates. Because teenage marriage and childbearing has a greater risk of negative repercussions than later unions (38), these lower marriage rates may have a positive health impact. Young parents acquire less education than their contemporaries; their marriages are less stable than those of their contemporaries who postpone childbearing, and couples who become parents as teenagers expect to have more children than they want (39).

Current Threats to Abortion for Teenagers

Two approaches are being used in the United States to limit the availability of legal abortion services for teenagers: (a) requiring parental notification/consent to obtain the procedure and (b) restricting public funds for abortion. Many "Akron-type" ordinances have been passed at state and local levels mandating that if a pregnant woman is < 18 years old and unmarried, her parents or guardian must be notified at least 24 hours before the procedure (40). If they cannot be located, a 72-hour waiting period is required to allow a certified notification to reach their last known address. While it is desirable to involve the teenager's parents in the abortion decision when possible, frequently their response is punitive rather than supportive. Moreover, these parental notification provisions create additional delays for many pregnant teenagers because anxiety about informing their parents leads to conflict in decision making (40). Counseling by trained adults can help the teenager decide whether to terminate her pregnancy and how to cope effectively with the emotional consequences of her decision.

Restricting public funds for abortion also affects teenagers who are eligible for public payments for medical services. Teenagers might qualify for public payment in one of two ways: (a) they could be dependent on parents who qualify for public funding for medical services or (b) they could be single parents who are eligible for public support. If they become pregnant, these low-income teenagers are eligible for public funding for medical services if they choose to continue their pregnancies but must finance their own abortions if they choose to terminate their pregnancies. Current data show that most low-income women who would once have used publicly funded, legally induced abortion to terminate unwanted pregnancies continued to obtain legal abortion, using instead a combination of personal funds and state-based subsidy (41). Nonetheless, these women with limited funds who must at least partially pay for abortion services do not have this money available for other necessities. The effects of these financial compromises have not yet been determined.

Conclusion

Despite the fact that teenagers are more negative about abortion than older women, teenagers are apparently more likely to use legal abortion to prevent unplanned births. The most important variable affecting teenagers who have abortions is that the procedures are performed significantly later in pregnancy. After adjusting for this factor, teenagers have generally lower morbidity and mortality rates than do older women from legally induced abortion. For teenagers, the risk of dying from continuing an unplanned pregnancy to term is at least fivefold higher than that of terminating it.

The scientific literature is inconclusive about whether abortion methods used for today's teenagers will be associated with any harmful effects on later desired pregnancies. Rather than discouraging the use of contraception, the availability of legal abortion since 1970 has been associated with increased use of contraceptives by teenagers. Current efforts to restrict abortion services for teenagers will probably have a negative public health impact by encouraging delay once the decision to terminate a pregnancy has been made.

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Document #16

CHILDREN OF INCEST

Morton S. Adams, M.D., and James V. Neel, M.D., Ph.D.

Department of Human Genetics, University of Michigan, Ann Arbor, Michigan

INFORMATION on the nature of the children resulting from incestuous unions* has both practical and theoretical interest. It is of practical value in that there is a high probability that the pediatrician who serves as a consultant to agencies concerned with child placement will encounter such children and be requested to render an opinion concerning their suitability for adoption. It is of theoretical value because of the light that results of such close inbreeding throw on man's concealed genetic variability.

For many obvious reasons, the accumulation of unbiased data on the outcome of such unions, as well as suitable controls, presents difficulties, and, although there is an abundance of anecdotal material, objectively assembled series do not seem to exist. This report will describe a small series of 18 children resulting from such unions, and a like number of children whose mothers were, as nearly as possible, matched to the mothers of children of incest. The series was assembled through the cooperation of several agencies which are responsible for child care and placement in the state of Michigan.

METHODS

Prospective Ascertainment

To minimize the loss of information concerning still birth, neonatal death, and the possible selection of cases with particularly unfortunate outcomes, only cases of incest which were ascertained during pregnancy were included in the study. The mean duration of pregnancy at the time of ascertainment was 7 months. The study thus supplies no data on early fetal loss.

* Incest as used in this paper refers to brother x sister and father x daughter matings.

Determination of Paternity

Only cases of admitted and undisputed incest were accepted. Paternity exclusion tests were performed where possible to aid in the identification of children falsely reported to the agency as being the products of incest. The following genetic systems were examined by Dr. Henry Gershowitz, to whom we are most grateful: ABO, MNS (M^gN^g), Rh (D, D^u, C, c, C^w, E, e), Kitt (JK^a), Kell (K, k, Kp^a, Kp^b), Lutheran (Lu^a), Duffy (Fy^a), P, Wright (Wr^a), Lewis (Le^a, Le^b). There were no paternity exclusions in six mother-putative father-child combinations.

Long-term Evaluation of the Child

To increase the likelihood of detecting physical defects and to ensure a more accurate evaluation of mental status, all the children were examined at birth and, as near as possible, at the age of 6 months. Children with abnormal findings were followed up at varying intervals. A preschool examination when the children are age 6 years is planned.

Comparison Group

Since there was reason to suspect that the mothers of the study children did not represent a random sample of the population, they were matched as closely as possible to a comparison group with respect to age, race, weight, stature, intelligence, and socioeconomic status (Table 1). The comparison group was prospectively ascertained from unwed mothers under the care of the same agencies from which the incest cases were derived. This matching was also an attempt to remove effects attributable to the young age of the mothers and the fact that they were all primigravidae. Since the mothers in the comparison group were also

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PRESENT ADDRESS: (M.S.A.) Human Genetics Branch, National Institute of Dental Research, National Institutes of Health, Bethesda, Maryland 20014.

without the benefit of wedlock, nonspecific environmental effects peculiar to unwed mothers are at least partially controlled. Matching with respect to intelligence was difficult and a higher proportion of the women involved in incest were probably in the "dull" category.

Furthermore, of course, no matching procedure can compensate for the special psychic factors which enter into incest, factors conceivably influencing the outcome of pregnancy.[1] There was one unsuccessful abortion attempt among the father x daughter incest cases but none known among the non-incest mothers.

Estimation of the maternal intelligence was complicated by the obvious stressful situation in which the mothers found themselves. Therefore, various methods were employed including the Lorge-Thorndike Intelligence test administered by the authors and review of the results of previous psychometric testing while in school and school performance. Admittedly, these estimates are not completely satisfactory.

The babies were examined at birth by the obstetrician and/or pediatrician in attendance, and length, weight, and head circumference were measured. At the "6-month" examination, the babies were transported to the University of Michigan Medical Center where a developmental and a medical history was taken and a general physical examination was performed. Length, weight, head circumference, head height, and knee height were measured. Bone age was obtained from x-ray examination of the left wrist. Psychological testing with the Cattell Infant Intelligence test was performed by Dr. Ralph Gibson. He was not informed as to whether any given child was a product of incest.

RESULTS

The results to be presented can be divided into two groups: (1) observations

TABLE I

CRITERIA USED IN MATCHING MOTHERS OF INCEST AND COMPARISON CHILDREN

Kindred Number	*Incestuous Mother*					*Comparison Mothers*				
	Age	*Height*	*Weight (lb)*	*I.Q.**	*Socio economic*[13]	*Age*	*Height*	*Weight (lb)*	*I.Q.**	*Socio economic*[13]
7692	13	5' 4"	120	Average	1	14	5' 3"	123	100	2
9089	12	4' 10"	100	73	2	13	5' 3"	118	Average	1
8180	14	5' 3"	110	Average	2	14	5' 3"	125	Average	2
8289	14	5' 1"	100	105	1	16	5' 0"	95	High	2
9040	13	5' 6"	140	High	1	17	5' 5"	118	High	1
9042	13	5' 1"	94	80	3	13	5' 2"	130	Average	1
9134	16	5' 3"	134	High Average	2	16	5' 4"	130	High Average	4
8897	17	5' 2"	120	97	3	18	5' 2"	100	Average	3
8999	17	5' 4"	120	Average	4	16	5' 1"	108	Average	3
8069	17	5' 6"	170	111	2	17	5' 6"	130	High Average	4
8131	12	4' 9"	150	Average	1	13	5' 4"	125	114	4
8147	13	5' 5"	144	96	1	17	5' 5"	130	Average	3
8985	13	5' 2"	140	Low Average	3	13	5' 8"	130	Low Average	3
8198	16	5' 4"	112	88	4	21	5' 11"	160	Low	3
8886	17	5' 5"	118	High	2	17	5' 6"	125	High Average	2
8998	20	5' 2"	102	75	3	19	5' 3"	110	Average	4
8199	16	5' 0"	165	77	3	14	5' 7"	120	Low Average	4
7691	20	5' 3"	144	High	2	20	5' 5"	120	Average	4

* Low <90; average 90-109; high>110.

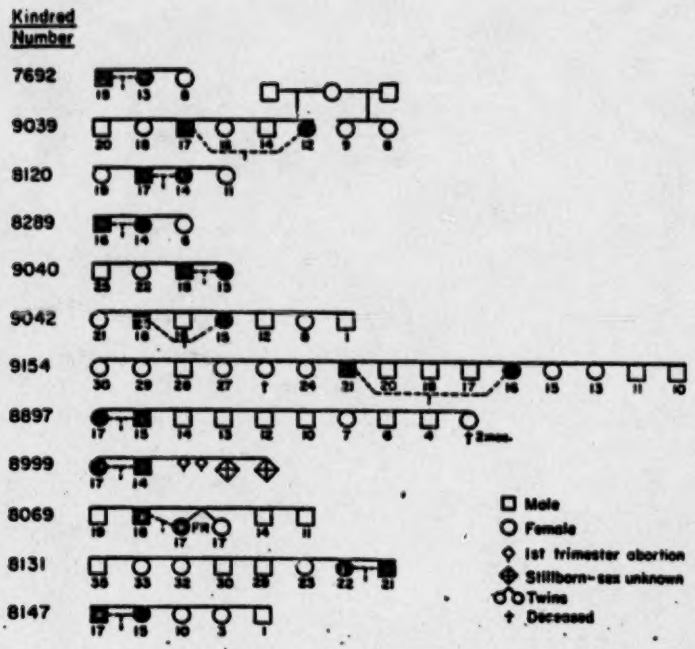

FIG. 1. Pedigrees of 12 cases of brother x sister incest.

which characterize the circumstances surrounding the production of a child of incest, the "ecology of incest," and (2) observations on the effects of incest on mortality, morbidity, and the growth and development of children who have this background.

The Ecology of Incest

BROTHER-SISTER MATINGS (FIG. 1): The involved sibs, excepting one case, were of average intelligence (range in I.Q.'s: males, 90–120, average, 110; females, 90–120, average, 103). The exceptional case involved a girl with an estimated I.Q. of 73 and her brother who was alleged to possess low average intelligence. All couples were in good health and there was no history of familial disease. In general, the socioeconomic condition of these families was not low. The occupations of the head of the household were all skilled and semiskilled. Several of the siblings of the incestuous couple had achieved college educations. The age of the female members of the couples in all but five cases were between 12 and 15 years (range, 12 to 22; average 15.6). On the average the males were 3 years older. It must be re-emphasized that while the above generalities make the brother x sister matings seem stereotyped, the situation is very complex and psychiatric evaluations are not available. As mentioned earlier, the intelligence of these young women was evaluated during a time of stress.

FATHER-DAUGHTER MATINGS (FIG. 2): The father x daughter matings were of somewhat different character. The females were older (range, 13 to 20, average, 17) than the sib pairs. Only one was less than 16 years and she was severely retarded mentally. These females were of widely divergent intelligence. One had completed 2 years of college and another was an honor student in high school. On the other hand, three of the other mothers had estimated I.Q.'s of 58, 75, and 77. The fathers

TABLE II

RESULTS OF EXAMINATIONS: BROTHER-SISTER INCEST GROUP

Kindred Number	*Physical*	*Developmental Quotient*
7602	7 lb, 13 oz, Caucasian female, failure to thrive. At age 2 mo became febrile with hepatomegaly. Died 1 hr after admission. Autopsy: hepatic glycogen storage disease, horseshoe kidney, chronic leptomeningitis.	None done
5039	5 lb, 12 oz, Caucasian male, age 2 mo, poor head control. Age 4 mo, seizures. Age 6 mo, areflexic, 3 × 3 cm bony defect in right occipital parietal region, bone age retarded.	Severe retardation.
8120	8 lb, ½ oz, Caucasian male. Normal. Bone age advanced.	92, age 4 mo 94, age 17 mo 68, age 40 mo
8280	6 lb, 2 oz, Caucasian female, left int. strabismus bilat. tibial torsion, bone age retarded. PBI-6.2 mcg %.	64, age 6 mo 79, age 18 mo 64, age 24 mo
9040	6 lb, 9 oz, Caucasian male. Respiratory distress at 6 hr. Died at 15 hr. Autopsy: pulmonary hyaline membrane.	None done
9042	5 lb, 15 oz, Caucasian female. Normal except treated for right acetabular dysplasia.	112, age 6 mo
9154	6 lb, 1½ oz, Caucasian female. Normal except for small hemangioma on right anterior chest.	119, age 6 mo
8807	6 lb, 12 oz, Caucasian female. Normal except treated for left acetabular dysplasia.	85, age 6 mo
8809	7 lb, 9 oz, Caucasian female. Normal.	118, age 6 mo
8069	5 lb, 10 oz, Caucasian female. Failure to thrive, but no abnormality.	64, age 14 mo 80, age 20 mo 56, age 26 mo 72, age 40 mo
8131	6 lb, ½ oz, Caucasian male. Normal.	64, age 6 mo 72, age 12 mo 71, age 24 mo
8147	7 lb, 3 oz, Negro male. Normal.	99, age 6 mo

were generally poorly educated and held jobs requiring low to average ability. The family living conditions and standards were frequently, by the usual sociological criteria, grossly deficient.

Effects of Incest (Tables II through VI)

GROWTH AND DEVELOPMENT: There was a normal sex distribution in both the incest and comparison group (incest, 8♀ : 10♂; comparison, 9♀ : 9♂). The average full-term child of incest was approximately one-half pound lighter at birth than the non-incest children of like sex. Although the average maternal age of both the incest and comparison groups was 16 years, none of the control mothers were as young as three of the incest mothers, a fact per

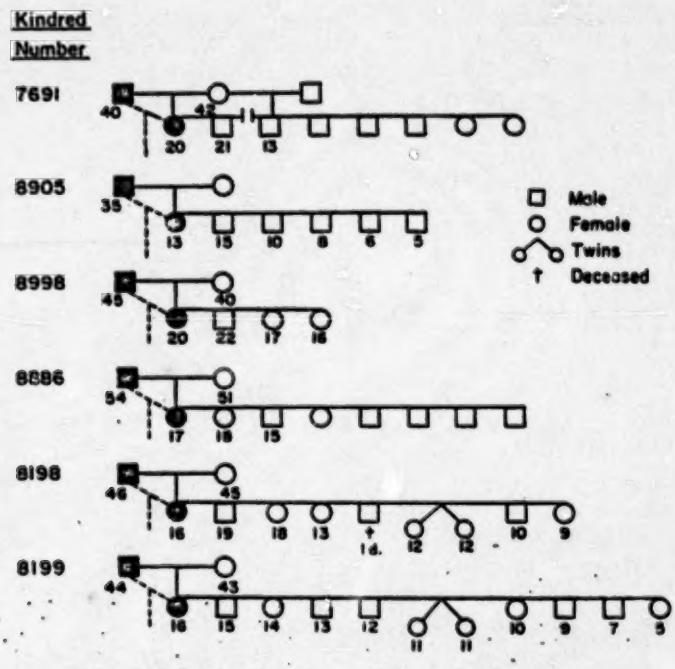

FIG. 2. Pedigrees of six cases of father x daughter incest.

haps relevant to the differences in mean birth weight. There was one premature birth (birth weight less than 5 lb) among the children of incest and two among the controls. The measurements of length and head circumference showed no clear-cut difference between the children of incest and the controls.

MORTALITY AND MORBIDITY—INCEST CHILDREN: Seven of the 18 children of incest were normal at the 6-month examination and adoption was recommended. Their I.Q.'s ranged from 98 to 119, average 110. The remaining 11 children of incest either had died or suffered from some degree of morbidity. Two of the children died in the neonatal period; one, a 1,100 gm premature infant, died within 6 hours and an autopsy was non-diagnostic. One full-term infant died at 13 hours with the respiratory distress syndrome. Pulmonary hyaline membranes were demonstrated at autopsy. Another died at the age of 2 months following an acute febrile illness of unknown etiology and was found on necropsy to have glycogen storage disease. One child had a bilateral cleft lip. Two others were severely retarded mentally, with seizure disorder and spastic cerebral palsy, and they were institutionalized. In none of these cases was the family history contributory. Three children were less severely retarded mentally, having estimated intelligence quotient's (I.Q.'s) of about 70 on repeated testing. Although mental testing at this age is difficult, the consistency of the retest results gives some credibility to the impression. However, final judgment on cases of this type is suspended.

MORTALITY AND MORBIDITY—COMPARISON CHILDREN: None of the comparison children died and none were institutionalized. None had an estimated I.Q. of less than 80 at age 6 months and only in three cases was adoption deferred awaiting repeat psychometric evaluation. Four congenital anomalies were diagnosed in as

TABLE III

RESULTS OF EXAMINATIONS: BROTHER-SISTER COMPARISON GROUP

Physical	Developmental Quotient
9 lb, 3½ oz, Caucasian female treated for acetabular dysplasia. Normal at age 8 mo.	101, age 8 mo
8 lb, 2 oz, Caucasian female, growth and development normal.	107, age 9.5 mo
3 lb, 9 oz, Caucasian male. Normal.	81, age 4 mo
6 lb, 9 oz, Caucasian male. Normal except left cryptorchidism.	100, age 10 mo
8 lb, 6 oz, Caucasian male. Normal.	100, age 18 mo
5 lb, 5 oz, Caucasian male. Normal.	105, age 8½ mo
7 lb, 13 oz, Caucasian female. Normal.	95, age 3 mo
4 lb, 6½ oz, Caucasian male. Age 2 mo bilateral inguinal hernia.	103, age 13 mo
8 lb, 2½ oz, Caucasian male. Normal.	133, age 6 mo
9 lb, 4 oz, Caucasian male. Normal.	109, age 4 mo
7 lb, 6 oz, Negro male. Normal.	91, age 9 mo

many children:† a branchial cleft cyst, unilateral cryptorchidism, bilateral inguinal hernia (male), and ptosis of the left eye. Only the branchial cleft cyst would be termed "major" by the criteria of Schull and Neel.[2] The range of I.Q. in the 15 children who were recommended for adoption was 91 to 133, average 105.

COMMENT

The frequency of death-plus-major defect[2,3] in the comparison group was 1 in 18 ($5.6 \pm 5.4\%$) and in the children of incest, 6 in 18 ($33.33 \pm 11.1\%$). In addition, three of the children of incest, on the basis of repeated intelligence tests, are probably functioning in the retarded range. Interestingly, these children were not born to the mothers felt to be mentally subnormal. The present series thus suggests that the children of incest are a "high-risk" group, to the extent that the pediatrician consulted concerning the early placement of such a child is well advised to evaluate the child with special care.

Schull[4] reported that in a large cohort of newborn Japanese infants the frequency of death-plus-major congenital defect was 4.3% in the control children and 6.2% in the offspring of first cousins. Neel and Schull,[5] and Schull and Neel[2] found that in a subset of the same cohort followed until an average age of 8 years (the evaluation now included a judgment concerning mental retardation) the frequency of death-plus-major defect was estimated as 17.4% in controls and 22.4% in the children of first cousins. Although there has been a wide variation in the results of other studies on this problem, Schull and Neel,[2] after a review of the existing data, concluded that the differences might all be explained by sampling error and "experimental design" and that there was as yet no compelling evidence for real differences in inbreeding effects from area to area and race to race. The above quoted Japanese studies are near the mean of the various studies to date; we, therefore, feel justified in using them for purposes of comparison. The data suggest that, in round terms, no more than 4 to 5% greater frequency in death-plus-defect would be expected in the children of first cousins than in control children under the circumstances of the Japanese study. In the children of a first cousin marriage, the probability that a child will be homozygous for a specific gene present in one of the two grandparents is .0625. In a child of incest, this same probability is 0.250. Accordingly, a simple linear extrapolation from these studies on the effects of inbreeding in first cousins to the outcome of incestuous union would call for no more than a 16 to 20% increase in death-plus-defect in children such as we have studied. The observed increase is 28%.

Chance is, of course, the most likely explanation of the discrepancy between observation and expectation in this small series. In this connection it should be noted that, in view of the high risk of still birth, neonatal death, and congenital defect in the children of very young mothers,[6-9] the record of the comparison group appears to be better than would usually be the case.

† Although the diagnosis of acetabular dysplasia was made three times by competent pediatricians in these 38 children, the difficulties with this diagnosis in the newborn[10] are such that it has not been included in the calculations although it is listed in the tables.

TABLE IV

RESULTS OF EXAMINATIONS: FATHER-DAUGHTER INCEST GROUP

Kindred Number	*Physical*	*Developmental Quotient*
8905	7 lb, 5 oz, Caucasian male. Normal.	114, age 6 mo
8198	6 lb, 3¼ oz, Caucasian male. Failure to thrive, cortical atrophy, spastic cerebral palsy, seizures.	Severe retardation
8886	7 lb, 8 oz, Caucasian male. Bilateral cleft lip.	92, age 11 mo
8098	8 lb, 9 oz, Caucasian male. Normal. n.b. Unsuccessful abortion attempt during third month.	113, age 6 mo
8199	1,100 gm, Negro male. Died age 6 hr. Autopsy: nondiagnostic.	None done
7691	6 lb, 2 oz, Negro female. Normal.	98, age 9 mo

although for lack of truly comparable data a precise statement is impossible. However, two other possible explanations must be considered. One is that the incestuous and the non-incestuous unions have not been properly matched, especially as regards mental attributes or certain psychic factors whose role in pregnancy outcome remains ill-defined.[1] In this connection, it should be recalled that the three borderline mentally defective infants born to the incestuous unions have not been included in these percentages. In view of the unusual nature of incestuous unions, it is obvious that this possibility will not be easily disposed of in this or any other study. The other possibility is that the regression of death-plus-major defect on inbreeding is non-linear in man, implying synergism in the action of genes rendered homozygous through inbreeding.[2,10]

The preliminary nature of the present data is apparent. The event under consideration is rare. The 18 children described in this paper were ascertained between January 1961 and March 1965. During this period an additional nine pregnancies resulting from incestuous unions were ascertained after the mother had delivered or under other circumstances excluding them from the study, for which reason the resulting children were not included in this report. On the basis of extensive contacts with the various agencies concerned, we estimate that at least 20 such pregnancies may occur in the state of Michigan annually. There is no reason to postulate that Michigan is unusual in this respect. It is to be hoped that the future will bring further reports on this important source of genetic information, especially in view of the provocative aspects of the present findings.

SUMMARY

Eighteen prospectively ascertained cases of brother x sister and father x daughter matings are described. A series of illegitimate children whose mothers were as nearly matched as possible to the incest mothers for intelligence, age, height, weight, and socioeconomic conditions were used as controls. Six of the children of incest had died or were found to have major defects on follow-up 6 months after birth date, whereas one of the comparison children was so classified. This is a larger inbreeding effect than would be predicted on the basis of published findings from marriages of first cous-

TABLE V

RESULTS OF EXAMINATIONS: FATHER-DAUGHTER COMPARISON GROUP

Physical	*Developmental Quotient*
7 lb, 6 oz, Caucasian female. Normal.	83, age 13 mo
10 lb, 10 oz, Caucasian male. Branchial cleft cyst.	93, age 13 mo
7 lb, 9 oz, Caucasian male. Normal.	108, age 17 mo
5 lb, Caucasian female. Ptosis left eyelid. Recurrent pneumonia, sweat chloride 18 mEq/l.	80, age 9 mo
6 lb, 1 oz, Negro female. Normal.	91, age 11 mo
5 lb, 15 oz, Negro female. Normal.	104, age 8 mo
	108, age 7 mo

ins. The series is published at this time to encourage others to collect these important, but rare and elusive data, in a prospective, controlled manner.

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Acknowledgment

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The sincere whole-hearted cooperation of the many child placement agencies of the state of Michigan was most gratifying. We acknowledge in particular those agencies which referred the children included in this study: Michigan Children's Aid Society, Bethany Christian Home, D. A. Blodgett Homes for Children, St. Agnes Foundling Home, Bureau of Social Aid of Kalamazoo County, and Children's Division, State of Michigan Department of Social Service.

Document #17

How Patients View Mandatory Waiting Periods for Abortion

By Michael Lupfer and Bohne Goldfarb Silber

Summary

In recent years, various legislatures have enacted laws and ordinances mandating a waiting period for women seeking to obtain abortions. Legal challenges to such statutes have been successful, except in one instance (Akron, Ohio), and a federal judge in Tennessee recently struck down a waiting period statute.

As part of the appeal against the Tennessee law, two surveys were made of some 400 women who experienced such a delay to probe their opinions about the benefits and drawbacks of the mandated waiting period. More than seven in 10 women were unable to name a single benefit to be derived from waiting, and six in 10 pointed to one or more problems they had experienced, including extra expense, missed work or school, experiencing some discomfort and entering the second trimester of pregnancy, among others. About $7,600 in extra expenses were incurred by about 200 of the women (with a median of $24 per woman), adding about 48 percent to the costs for the typical low-income woman and 14 percent for the typical higher income woman. The cost of the second visit increased in direct proportion to the distance a woman lived from the family planning clinic and to the number of hours she was employed per week. The typical woman was found to hold a negative view of the statute. Women who were surveyed before and after the waiting period said that they actually realized fewer benefits and experienced more problems from the waiting period than they had anticipated.

Seven in 10 women required to go through a waiting period prior to obtaining an abortion said that they disapproved of such a delay. Waiting periods raised the cost of the procedure for typical low-income women by at least 48 percent and for higher income women by 14 percent.

Introduction

Laws requiring waiting periods have been overturned or enjoined in Illinois, Louisiana, Maine, Massachusetts, Missouri, Nebraska, North Dakota and Rhode Island.[1] There have been conflicting opinions in Kentucky about the constitutionality of waiting periods. In 1976, the U.S. Court of Appeals for the Sixth Circuit upheld the constitutionality of a 24-hour waiting period imposed by a 1974 Kentucky law.[2] In December 1980, however, a federal district court struck down that law. In doing so, the district court pointed out that unlike the plaintiffs in the case being heard, the plaintiffs in the earlier sixth circuit case did not present any evidence that the waiting period "would, in effect, impose increased health risks or increased financial burdens upon pregnant women seeking an abortion."[3] A waiting period requirement has been upheld in Akron, Ohio, and is being appealed; a similar law had been in effect in Tennessee,[4] but was struck down on March 23 by the federal court in which the case had been pending.[5] The court held that the waiting period imposed an undue burden on the women.

The Tennessee statute, originally adopted in March 1978, required that a woman seeking an abortion, after being examined by her physician and informed of the "benefits and risks . . . attendant either to continued pregnancy and childbirth or to abortion,"[6] must wait at least two days before having an abortion. The penalty for ignoring the waiting period was one to three years' imprisonment of the physician who performed the abortion.

Efforts to challenge the Tennessee law began as soon as it went into effect in September 1979; although the issue has been resolved in that state, the effort to impose mandatory waiting periods may continue in other jurisdictions. One aspect of the Tennessee case is, therefore, of special interest. Attorneys for the plaintiffs, reviewing similar cases elsewhere, noted that no attempt had been made to evaluate systematically and empirically the impact of the law, i.e., to gauge the effect of the mandatory waiting period on women seeking abortion. We were commissioned to assess the law's impact, by conducting two surveys of women who were candidates for abortions at clinics in Memphis and Knoxville from October 1979 through January 1980.*

The surveys were designed to measure the benefits and costs of the waiting period for abortion candidates: What benefits did the women believe they derived by waiting? What problems did the waiting period create for them? What costs, if any, did they incur by having to return to the clinic a second time? In addition, we wanted to determine whether the women favored or opposed the required waiting period.

The first survey focused on women who had already completed the waiting period. The second survey, identical in content to the first, questioned women both before and

Michael Lupfer is Professor of Psychology and Bohne Goldfarb Silber is a doctoral student in the Department of Psychology, Memphis State University, Memphis. The authors acknowledge the assistance of the staffs of the Memphis Association for Planned Parenthood, the Memphis Center for Reproductive Health and the Knoxville Center for Reproductive Health in conducting the surveys reported in this article. In addition, they are indebted to Gail O. Mathes, counsel for the Memphis Association for Planned Parenthood, and G. Philip Arnold and Thomas M. Daniel, attorneys for the West Tennessee American Civil Liberties Union, who served as the plaintiff's legal team. A different version of this article was submitted as an exhibit in the case of *Planned Parenthood of Memphis et al.* v. *Alexander et al.*, Case No. C-78-2310, U.S.D.Ct. W.D. Tenn. (1978).

*The surveys were commissioned by the Memphis Association for Planned Parenthood.

after the waiting period, to determine whether any appreciable change in outlook had occurred as a result of waiting.

Respondents and Interviews

A total of 332 women constituted the sample in the first survey.* They were randomly drawn from among abortion candidates at three clinics in Memphis and Knoxville, in numbers reflecting the proportionate volume of patients treated at the three centers. All of the women were interviewed during October–December 1979; prior to the interview, they all had received counseling, had been examined by a physician, had completed the mandatory wait and had signed the necessary consent forms for abortion.

Goodness-of-fit tests indicated that the sample was comparable to the population of Tennessee's women who have obtained abortions in terms of age, but contained 10 percent more nonwhites. In addition, the sample consisted entirely of women seeking abortions at outpatient, freestanding clinics, whereas only 88 percent of all abortion patients in Tennessee have obtained the procedure at such clinics; the remainder did so at hospitals or physicians' offices.[7]

Ninety-four women, all of whom were patients at the Memphis Association for Planned Parenthood's abortion clinic, were asked to participate in the second survey, conducted during the period January 12–24, 1980. All had already received abortion counseling and undergone laboratory tests, and were awaiting medical examinations, prior to the waiting period. Four of the 94 indicated uncertainty about proceeding with the abortion; to avoid any possibility that the interview itself might influence their decision, these women were not interviewed. The other 90 women completed the interview prior to the waiting period, and 73 of them, upon returning to the clinic after the waiting period, were reinterviewed.†

In the first survey, 69 percent of the respondents were white; 32 percent were teenagers and 40 percent were aged 20–25; 55 percent had no children and 26 percent had one; 62 percent were employed; 33 percent were students; 52 percent lived in the city where the clinic was located; 55 percent were interviewed at the Memphis Association for Planned Parenthood. In the second survey, the proportion of whites was slightly lower (60 percent); the proportion with no children, slightly higher (62 percent); and all the respondents were interviewed at the Memphis Association for Planned Parenthood.

All interviews for the first survey were conducted by counselors employed at the three clinics. These counselors, all of whom had a great deal of interviewing experience, were given instructions which stressed the importance of maintaining complete neutrality. They were admonished neither to express their own views nor to comment on the respondents' views. In addition, the counselors' interviews were spot-checked by their supervisors to assure reliability. The project directors monitored the recorded interviews to check for accuracy and completeness. As a result of this scrutiny, 51 of the original 383 interviews in the first survey were discarded as incomplete or possibly unreliable, reducing the final sample to 332 interviews.

The majority of the interviews for the second survey were conducted by a graduate student in psychology, and full-time counselors at the Memphis Association for Planned Parenthood conducted the remainder. Once again, all interviewers were given thorough instructions for conducting the interviews. None of the abortion candidates was interviewed by the same individual who had served as her abortion counselor.

Three drafts of the interview schedule were tested before the schedule used in the first survey was adopted. The interview schedule began with open-ended questions which permitted respondents to express their views in their own words, and progressed to specific, standardized attitude statements with which respondents were asked to agree or disagree. Every attempt was made to ensure that the open-ended questions were unbiased. Even in the latter part of the interview, when declarative attitude statements were introduced, statements were included that reflected both favorable and unfavorable attitudes toward the statute. (Six of the 10 attitudinal statements were favorable, and four were unfavorable; a slight positive bias was thus injected in the latter part of the interview.)

Deciding to Have an Abortion

The first questions in the earlier survey assessed the amount of time respondents took to decide to have an abortion, and also the amount of time that elapsed between the date of the decision and the date of the abortion itself. The majority of respondents (59 percent) said that they had decided to have an abortion within 24 hours after receiving confirmation of their pregnancy, although the range of responses was 0–75 days. Two overlapping groups of women—black women and mothers of two or more young children—reported, however, that they had deliberated 2–3 days, on the average, before reaching the decision to have an abortion. Once having made the decision, white women most typically obtained the abortion 14 days later and black women, 21 days later.

The overwhelming majority of women (88 percent) reported that they had talked with at least one person prior to meeting with the clinic counselor. Most commonly, respondents indicated that they had talked with their partner (42 percent) or a close friend (35 percent) about the advisability of an abortion. Less frequently, the respondents stated that they had talked with their mothers (17 percent); fathers (three percent); other relatives, including siblings or aunts (12 percent); health professionals, such as nurses or family physicians (seven percent); ministers or guidance counselors (two percent); or others (two percent).

The Benefits and Costs of Waiting

Early in the interview, respondents were reminded of the waiting-period requirements and were asked, "Did you gain any benefits by waiting a few extra days to have the abortion?" Seventy-seven percent of the women were unable to name a benefit, whereas 23 percent named one or more. Among the benefits were the following:

- had time to consider the wisdom of the decision (15 percent);
- had time to adjust psychologically (seven percent);
- had time to learn about the medical aspects of abortion (four percent);
- had time to consider effects of abortion on others (two percent); and
- other (two percent).

In response to the question "Did waiting a few extra days create any problems for you?" 41 percent were unable to name any problems, while 59 percent identified one or more problems. Among the problems named were these:‡

- experienced additional mental anguish (29 percent);
- incurred additional transportation expenses (24 percent);

*We calculated with 95 percent confidence that percentage estimates drawn from a sample of this size contained sampling errors of 4–6 percent.

†The remaining 17 women were not reinterviewed for the following reasons: Seven returned to the clinic to complete the abortion procedure after interviewing had ceased; four were discovered to have entered the second trimester of pregnancy and were referred elsewhere; two were referred elsewhere for medical problems and did not return; two decided to continue their pregnancies; one miscarried during the waiting period; and one did not return for unknown reasons. The responses of these 17 women to the initial interview questions were compared with the responses of the 73 women who were reinterviewed; no significant differences were found.

‡This was an open-ended question, and the women did not include financial matters pertaining to the waiting period as among the problems (although some did make mention of additional transportation costs and work missed). Either the question was not clear enough or costs were placed in another category in the respondents' minds.

- experienced additional nausea (19 percent);
- missed additional time at work (15 percent);
- had to make up extra excuses to explain absences (15 percent);
- others had to miss additional time at work to transport me (eight percent);
- missed additional time at school (six percent);
- had to arrange for additional babysitters (five percent);
- may have entered fourth month of pregnancy (one percent); and
- other (seven percent).

Table 1. Percentage of respondents agreeing with, disagreeing with or undecided about various statements concerning the waiting period, Memphis and Knoxville, 1980 (N=332)

Statement	Percent		
	Agree	Disagree	Undecided
The required waiting period has been beneficial because it has given me time to think to be sure I was doing the right thing.	42	55	2
I'm afraid that postponing the abortion for a few days has increased the chance that people will find out.	36	58	6
Postponing the abortion has been helpful because it has given me extra time to prepare myself mentally for what's to come.	39	55	6
The few days of required waiting have not made me any more nervous than I was already.	44	55	1
I thought carefully about the morality of having an abortion before coming here the first time. I didn't need the required waiting period to think more about that question.	82	16	2
Even though I've experienced some nausea and stomach upset during this pregnancy, the extra days of waiting have not added to my discomfort.	43	53	5
The required waiting period has been beneficial because I have learned more about the medical aspects of abortion during the wait.	35	62	3
Having to wait for the abortion has caused a lot of added stress and worry about my condition.	60	36	3
The required waiting period has been helpful because it has given me a chance to reconsider the abortion with people close to me.	30	69	2
Having to make an extra trip here has forced me to make up additional excuses and "stories" to explain my absences.	51	47	2

Economic Impact

The statute, because it required multiple visits to clinics, increased the costs of health care for many women seeking abortions. Of the 332 women interviewed for the first survey, 313 were able to provide estimates of the costs of compliance with the statute. Of these, 62 percent reported that the necessity of returning for a second visit cost them additional money in terms of reduced salary, transportation expenses or additional child-care expenses.* For the 194 women who reported additional expenses because of the required second visit, the total cost was $7,602, and the median was $24 per woman. Since the cost of the abortion itself ranged from $50 to $175, depending upon the woman's economic circumstances, compliance with the statute increased costs for the typical low-income woman by at least 48 percent and for the typical higher income woman by at least 14 percent.

We submitted each woman's expenses resulting from compliance with the statute to regression analysis to detect factors which contributed most directly to her expenses. Two factors were identified: the distance a woman lived from the clinic and the number of hours she was employed each week.† Compliance was more costly for women in rural than in urban areas and for women who were employed than for women who did not work. Regression analysis produced no evidence that the costs of compliance with the law differed according to the women's race, age, income level or student status.

The costs of compliance were broken down into components, and each was examined in detail:

- *Transportation expenses.* Forty-eight percent of all respondents lived in communities other than the one in which they were being treated—typically, some 80 miles from the urban center where the clinic was located. Among all respondents, including those who lived in the city where they were to obtain the abortion, 59 percent reported having to bear extra transportation expenses in order to return for the second visit. The median additional cost was $15.
- *Employment and salary.* Sixty-two percent of the sample reported that they had full-time or part-time jobs. Sixty percent of employed women stated that they had to miss time at work in order to return for the second visit, and 41 percent of all jobholders reported losing pay because of the required second visit. The median amount of pay lost by jobholders was $32.
- *Child-care expenses.* Forty-five percent of respondents were mothers—typically, with one or two young children at home. Among mothers with young children, 57 percent had to arrange for additional child care in order to return for the second visit, and 22 percent had to pay for this extra child care. The median payment was $10.

In addition, students comprised 33 percent of the sample; about 41 percent of the students had to miss classes in order to comply with the statute. On the average, students missed two additional days of classes in order to make the second visit.

Attitudes Toward the Statute

Part of the interview was devoted to assessing the women's attitudes toward the mandatory waiting period. Two types of attitude measurement were used: a structured question soliciting the women's attitudes; and a Likert-type attitude scale requiring respondents to agree or disagree with a series of opinions about the waiting period.‡

All respondents were asked: "As you know, the law has required you to wait a few days before having the abortion. Do you think that was a good idea, or would it have been better to have the abortion on your first visit here?" Seventy-one percent of the women in the first survey reported that they believed the law was not a good idea, compared with 26 percent who considered it a good idea. About three percent indicated that they were undecided about the law's merits.

As Table 1 shows, the majority of women

*Respondents were not asked to estimate the cost of lodging or income lost by family members or friends who missed work to provide transportation.

†Standardized correlation coefficients (beta) = 0.40 and 0.27, respectively.

‡Responses to the two types of questions were significantly correlated (r=0.64). This coefficient, plus the Cronbach's alpha coefficient of 0.82 for the Likert attitude scale, provided evidence for the reliability of the measures. (For a discussion of Cronbach's alpha coefficient, see: J. C. Nunnally, *Psychometric Theory*, 2nd ed., McGraw-Hill, New York, 1978, pp. 229–230.)

also expressed negative attitudes toward the statute in responding to the 10 statements forming the Likert attitude scale. Their responses to the statements were aggregated to yield for each woman a single attitude score on the scale. Scores on the Likert scale ranged from 10, indicating maximum approval of the statute, to −10, indicating maximum disapproval of the statute, with 0 being the neutral point. The mean score for all women was −1.9, suggesting that the typical woman had a negative view of the statute mandating a waiting period.

We submitted the composite attitude scores to regression analysis to identify factors which distinguished supporters from opponents of the statute. Seven significant factors emerged and are listed below, in decreasing order of their power to discriminate opponents from supporters. Opponents of the statute, who constituted the majority of the respondents, tended to be women who reported no benefits from the waiting period, could name one or more problems created by the wait, reached the decision to have an abortion in a short period of time, were older, were white, incurred extra transportation expenses because of the required second visit, and were patients at the Memphis Center for Reproductive Health.

The minority of women who favored the required waiting period were distinguished primarily by their ability to name one or more benefits but no problems resulting from the mandatory wait; by their tendency to take a longer time to reach a decision to have an abortion; by their youth; and by their not incurring any extra transportation expenses.

Views Before and After Waiting

The primary purpose of the second survey was to determine whether the women's views of the required waiting period had changed from the first clinic visit, before they had gone through the waiting period, to the second visit, after they had experienced the mandatory wait.

Although there was a high correlation* between the responses made at the first and second interviews, respondents' expectations about the benefits and costs of the waiting period proved to be significantly different from the benefits and costs they actually experienced. Table 2 shows that the women realized fewer benefits and more problems from the wait than they had anticipated. When initially asked, "Do you think you will gain any benefits by waiting a few days to have the abortion?" 16 percent of the women were able to name one or more expected benefits. This proportion dropped to seven percent by the end of the required waiting period.

More striking were changes in response to the question, "Do you think that waiting a few days for the abortion will cause any problems for you?" Prior to the waiting period, 46 percent anticipated one or more problems. This proportion rose to 64 percent following the mandatory wait, the increase being due primarily to four problems (not shown): more nausea and physical discomfort than expected (a shift from 10 percent who anticipated this problem to 25 percent who experienced it); a greater occurrence of mental anguish (from 10 percent to 25 percent); a greater need to lie and make excuses to explain absences (from one percent to 12 percent); and a greater incidence of transportation expenses (from 16 percent to 25 percent).

The actual financial costs of returning for the second visit also turned out to be greater than expected for the women in the second survey. At the time of counseling, the typical woman expected that the necessity of a second visit would cost her approximately $15 in terms of reduced salary, extra transportation expenses and additional child-care expenses. In fact, the median cost was $29 per respondent.

Table 2. Comparison of responses to key questions before and after the waiting period, and scores on the Likert attitudinal scales, by various measures (N=73)

Measure	Before waiting period	After waiting period	Test of significant change
% who could name no benefits of required wait	84	93	z=2.40*
% who could name one or more benefits	16	7	
% who could name no problems caused by required wait	54	36	z=2.99†
% who could name one or more problems	46	64	
Total cost incurred by having to make 2nd visit	$15	$29	t=6.07†
% who thought waiting period a good idea	25	21	z=0.82
% who disapprove of wait	70	73	
% undecided	5	5	
Mean scores on Likert attitude scale‡	−2.0	−2.5	t=1.56

*p<0.05. †p<0.01. ‡Scores range from −10 to +10.

Attitudinal Change

We also examined the women's attitudes toward the statute before and after the required waiting period. As shown in Table 2, both measures of women's attitudes (their responses to the structured question and their scores on the Likert attitude scale) revealed slight but nonsignificant shifts in the direction of greater opposition to the statute. Before experiencing the waiting period, 70 percent of the women disapproved of the required wait. This proportion increased to 73 percent by the time of the second visit.

During the same period, mean scores on the Likert attitude scale shifted slightly, from −2.0 to −2.5.† Altogether, the data suggest that no overall change in attitude toward the statute occurred as a function of experiencing the required wait.

Survey Data as Legal Evidence

Portions of the foregoing report were submitted on February 7, 1980, as an exhibit in a suit brought by the Memphis Association for Planned Parenthood against the state of Tennessee. The senior author was subsequently called to testify about the report. Most of the questions raised in cross-examination pertained to the methodology of the surveys, and specifically to the issue of interviewer bias.

We would like to describe more fully our responses to questions about interviewer bias because this issue figured so prominently in cross-examination. All the interviews in the first survey and a portion of the interviews in the second were conducted by family planning counselors who were employees of the plaintiff. For this reason, and also because many of the counselors were assumed to oppose the mandatory waiting period, the defense attorneys alleged that the counselors might have allowed their personal opinions to bias the interviewing process. According to this argument, the re-

*Test-retest correlations were all positive (from 0.47 to 0.87) and significant at the p<0.01 level.

†Because the composite score on the Likert scale was based on 10 responses, we assumed it was a more sensitive and reliable measure of attitude than the responses to the single question. The correlation coefficients (not shown in Table 2), which may be viewed as test-retest coefficients of reliability, support this assumption.

sponses of abortion candidates might not have reflected their own opinions as much as they reflected the biasing influence of the interviewers.

We acknowledged the potential danger of interviewer bias and pointed out the steps taken at the beginning of the project to minimize the danger: A detailed interview schedule to be followed precisely by the interviewers was written, leaving no opportunity for improvisation; declarative attitude statements were used, of which 60 percent expressed a favorable attitude toward the mandatory wait and the rest, a negative attitude (see Table 1); and the interviewers were given training which stressed the importance of neutrality. In addition, we pointed out that for the second survey, a graduate student in psychology who had no affiliation with any family planning organization conducted all of the interviews prior to the waiting period, as well as many of the interviews following the waiting period. The responses obtained in this survey by the graduate student (shown in Table 2) were remarkably similar to the responses obtained by the counselors in the earlier survey.

A further argument against the allegation of negative interviewer bias invoked the research literature on social influence. Several investigators[8] have found that susceptibility to social influence diminishes with age, i.e., that young adolescents are more susceptible than late adolescents, who, in turn, are more susceptible than adults. Accordingly, if the interviewers in the first survey were conveying a negative bias toward the statute and influencing respondents to conform to this bias, then we should have found the youngest girls expressing the most negative attitudes. In fact, the opposite results were obtained. Respondents under 18 years of age comprised the only age-group to express a favorable attitude toward the waiting period, their mean on the Likert scale being 0.7, compared to means of −0.8 for women aged 18–22, −3.5 for women aged 23–30, and −4.5 for women aged 31–40.

Therefore, we concluded that there was no tangible evidence to support the charge that negative interviewer bias accounted for the results obtained in the surveys.

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AND

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Petitioners,

v.

CITY OF AKRON,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF RESPONDENTS FRANCOIS SEGUIN, M.D. AND PATRICIA K. BLACK

[Counsel listed inside front cover.]

Washington, D.C. • THIEL PRESS • (202) 638-4521

ALAN G. SEGEDY (Counsel of Record)
DAVID G. UMBAUGH

SEGEDY, UMBAUGH & SHARP
Law & Commerce Building
40 E. Mill Street (at Main)
Akron, Ohio 44308
(216) 253-5535

ROBERT A. DESTRO

School of Law
Catholic University of America
Washington, D.C. 20064
(202) 635-5144

Attorneys for Respondents, Francois Seguin, M.D. and Patricia K. Black

DAVID G. UMBAUGH

SEGEDY, UMBAUGH & SHARP
Law & Commerce Building
40 E. Mill Street (at Main)
Akron, Ohio 44308
(216) 253-5535

Attorneys for Respondents, Francois Seguin, M.D. and Patricia K. Black

Of Counsel:

THOMAS P. MONAGHAN
Catholic League for
Religious and Civil Rights
1100 West Wells Street
Milwaukee, Wisconsin 53233

bearing age, who were intervening defendants in the trial court and appellants in the Court of Appeals for the Sixth Circuit, and who now support the position of Petitioner City of Akron. Opposing Respondents are abortion clinics Akron Center for Reproductive Health, Inc., *et al.*, and Dr. Robert Bliss, a Cincinnati physician.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED FOR REVIEW i

PARTIES i

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES v

OPINIONS BELOW 1

JURISDICTION 2

CONSTITUTIONAL AND STATUTORY PROVISIONS 2

STATEMENT OF THE CASE 3

SUMMARY OF ARGUMENT 12

ARGUMENT:

I. This Court Should Approve The Parental Consent/Judicial Alternative Provided By Section 1870.05(B) Of The Akron Ordinance 13

A. The Record Below Demonstrates That Only Immature Minors Are Affected By The Parental-Judicial Consent Provisions Invalidated By The Court of Appeals And The District Court 13

B. The Record Below Indicates That The Counselling Provided Immature Minors Is Inconsistent With Community Medical Standards For The Treatment Of Immature Minors, And The Respondent Clinics Make No Attempt To Distinguish Between A "Mature" And An "Immature" Minor 16

C. A State-Imposed Requirement Of Parental Consent Coupled With A Provision For Judicial Override Does Not Violate The Rights Of An Immature, Dependent Minor And Is Consistent With Community Medical Standards For The Treatment Of Minors In The Absence Of Parental Consent 19

Page

1. The Record In This Case Establishes The Respondent Clinics Simply Assume That A Minor Wants An Abortion If She Visits Their Facilities 19

2. Judicial Override/Consent For Necessary Medical Care Is Common Practice In Cases Where Parental Consent Is Withheld Or Otherwise Unavailable 20

D. The Clinics Did Not Challenge The Adequacy Of The Judicial Alternative To Parental Consent For Immature Minors Provided By Chapter 2151 Of The Ohio Revised Code 27

II. The Standard of Review In Abortion-Related Cases Should Be Clarified By This Court 31

A. The Standard Of Review In Abortion-Related Litigation Is Unclear And Leads To Conflicting And Illogical Results 31

B. The Standard Of Review Applied By The Sixth Circuit Court of Appeals For First-Trimester Abortion Regulation Was An Improper Standard Which Has Never Been Enunciated By This Court 33

C. A State Must Show A Compelling Interest In Support Of A Duly Enacted Abortion Regulation Only When Such Regulation Has Been Shown To Be Unduly Burdensome On The Right To Seek An Abortion, Even During The First Trimester Of Pregnancy 35

D. The Facts Of This Case Compel The Conclusion That The City Has A Compelling Interest In Assuring An Informed Consent For All Women Seeking Abortions, And That This Interest Is Greatly Magnified In Cases Involving Unemancipated, Immature Minors 36

CONCLUSION 41

SUPPLEMENTAL APPENDIX . . . . . Sup. App. 1

TABLE OF AUTHORITIES

Cases: *Page*

Abortion Coalition of Michigan v. Michigan Dept. of Public Health, 426 F. Supp. 471 (E.D. Mich. 1977) 31

Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981) 1

Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979) 1

Bellotti v. Baird (I), 428 U.S. 132 (1976) 4, 25, 35

Bellotti v. Baird (II), 443 U.S. 622 (1979) . . . . . *passim*

Bellotti v. Baird, 450 F. Supp. 997 (D.C. Mass. 1978) 24

Bigelow v. Virginia, 421 U.S. 809 (1975) 32

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) 34

Colautti v. Franklin, 439 U.S. 379 (1979) 34

Connecticut v. Menillo, 423 U.S. 9 (1975) 35, 37

Doe v. Bolton, 410 U.S. 179 (1973) 4, 32

Friendship Medical Center v. Chicago Bd. of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. den.*, 420 U.S. 997 (1975) 31

Ginsberg v. New York, 390 U.S. 629 (1968) 24

Goldberg v. Kelly, 397 U.S. 254 (1970) 29

H. L. v. Matheson, 450 U.S. 398, 101 S. Ct. 1164 (1981) . . . . . *passim*

Harris v. McRae, 448 U.S. 297 . . . . . 31, 35

In re Gault, 387 U.S. 1 (1967) 29

Lassiter v. Dep'ts of Social Services, 452 U.S. 18 (1981) 24

Maher v. Roe, 432 U.S. 464 (1977) 32, 35

Moore v. City of East Cleveland, 431 U.S. 494 (1977) 22, 23

Parham v. J. R., 442 U.S. 584 (1979) 24

Pierce v. Society of Sisters, 268 U.S. 570 (1925) 23, 24

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1967) . . . . . *passim*

Cases, continued: Page

Quilloin v. Wolcott, 434 U.S. 246 (1978) 24

Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*

Santosky v. Kramer, ___ U.S. ___, 71 L. Ed. 2d 599 ..... 22, 24

Singleton v. Wulff, 428 U.S. 106 (1976) 21

Wisconsin v. Yoder, 406 U.S. 205 (1972) 23, 24

Statutes and Ordinances:

Codified Ordinances of the City of Akron, Ohio:

Chapter 1870:

Section 1870.05(A) 5, 6

Section 1870.05(B) ..... *passim*

Section 1870.06(B) 5, 7, 41

Section 1870.06(C) 41

Section 1870.19 7

Ohio Revised Code:

Chapter 2151:

Section 2151.03 22

Section 2151.23 ..... 22, 24

Section 2151.27 ..... 22, 24

Section 2151.28 ..... 22, 24

Section 2151.281 22

Section 2151.33 22

Section 2151.421 ..... 22, 24, 25

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AND

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Petitioners,

v.

CITY OF AKRON,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF RESPONDENTS FRANCOIS SEGUIN, M.D. AND PATRICIA K. BLACK

OPINIONS BELOW

The opinions of the District Court and the Court of Appeals for the Sixth Circuit have been reported at 479 F. Supp. 1172 (N.D. Ohio 1979) and 651 F.2d 1198 (6th Cir. 1981), respectively.

JURISDICTION

Jurisdiction of this Court was invoked pursuant to 28 U.S.C. Sec. 1254(1). A petition for certiorari to the United States Court of Appeals for the Sixth Circuit was timely filed by each of the parties, and the petitions were granted in Nos. 81-746 and 81-1172 on May 24, 1982.

CONSTITUTIONAL AND STATUTORY PROVISIONS[1]

Ohio Revised Code—Sec. 2151.03

Ohio Revised Code—Sec. 2151.23

Ohio Revised Code—Sec. 2151.27

Ohio Revised Code—Sec. 2151.28

Ohio Revised Code—Sec. 2151.281

Ohio Revised Code—Sec. 2151.33

Ohio Revised Code—Sec. 2151.421

Codified Ordinances of the City of Akron—Sec. 2870.05

Codified Ordinances of the City of Akron—Sec. 1870.06

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[1] All relevant statutory provisions are quoted in full in the Supplemental Appendix to this brief and cited as (Supp. App. ___). Additional statutory provisions are found in the separately bound Appendix of the City of Akron.

STATEMENT OF THE CASE[2]

1. Proceedings Below

This litigation began as a challenge to the facial validity of Chapter 1870 of the Codified Ordinances of the City of Akron, Ohio (hereinafter "the City") pursuant to 42 U.S.C. Sec. 1983 and 28 U.S.C. Sec. 1331. Chapter 1870 was passed by the Akron City Council and was to have become effective on May 1, 1978, but a preliminary injunction restraining its enforcement was entered on April 27, 1978 by the United States District Court for the Northern District of Ohio, the Honorable Leroy J. Contie, Jr. presiding. A trial on the merits was held September 5-21, 1978. Final decision on the merits was rendered on August 22, 1979 (43a), and upon the filing of a motion to alter or amend the judgment pursuant to F. R. Civ. P. 59, the United States Court of Appeals for the Sixth Circuit original Memorandum Opinion and Order was modified by the order of the District Court filed on October 4, 1979 (107a). Timely appeals were filed by all parties in the trial court, and by opinion and order dated June 12, 1981 the Court of Appeals entered a split (2-1) decision affirming in part and reversing in part the opinion of the District Court (1a). Judge Cornelia Kennedy filed a concurring and dissenting opinion on the merits (25a). Motions filed by the parties for reconsideration were denied on July 10 and 22, 1981 (39a, 41a).

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[2] All references to the record are designated by a Roman numeral and number, referring to the Volume and Page of the transcript, *e.g.* (Tr. II, 23). All references, such as (43a), are references to the page in the separately-bound Appendix to Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit filed by the Petitioner City of Akron. All references to the Joint Appendix in this case are cited as (J.A. ___).

Petitions for certiorari were timely filed by all parties (Nos. 81-746, 81-854, 81-1172), and the writs in Nos. 81-796 and 81-1172 were granted on May 24, 1982. The writ was denied in Nos. 81-854, but the issues presented in that case were substantially identical to those presented in Nos. 81-746.

The interests represented in the litigation are those of the abortion clinics (hereinafter "clinics"); a physician (hereinafter "Dr. Bliss") who purports to represent the rights of clinic patients, including "immature minors, who desire abortions"; the City of Akron (hereinafter "City") in its capacity as the governmental entity which passed the law; and these Petitioners (hereinafter "parents" or "Mrs. Black" or "Dr. Seguin") who were permitted by the District Court to intervene as parties "in their individual capacity as parents of unmarried daughters of childbearing age."

This case raises several issues which have not been resolved by this Honorable Court since *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973). Among these are:

1. The appropriate standard of review in an abortion-related case;
2. The nature of and parties to the judicial proceeding held to be permissible in *Bellotti v. Baird (I)*, 428 U.S. 132 (1976), and *Bellotti v. Baird (II)*, 443 U.S. 622 (1979), including the right of parents of immature minors; and
3. The permissible extent of regulations which seek to further a truly "informed" consent to abortion, especially where immature minors are involved.

As intervening parties defendant in the trial court, and as appellants in the Court of Appeals, these Respondents

still seek to have upheld by this Honorable Court those provisions of the Akron ordinance which apply to their interests as parents of unmarried daughters of childbearing age. They assert their individual parental rights in that regard as well as the right of the City of Akron to protect those rights.

2. Statement of Facts

The statement of facts contained in the Brief of the City of Akron is adopted by reference insofar as it discusses issues other than those directly related to the interests of these Responents. The facts summarized below are limited to those directly relevant to the decision of questions 1 and 2 of the "Questions Presented" herein.

Respondents Francois Seguin, M.D. and Patricia K. Black are parents of unemancipated, immature, minor daughters of childbearing age. As intervening parties defendant at trial they were most directly concerned with the provisions of Sections 1870.05 and 1870.06(B) of the Akron ordinance at issue in this case. Section 1870.06(B) provides a set of guidelines for informed consent and, in so doing, seeks to ensure that women, minors, and their parents will have all facts necessary to make a truly informed decision regarding abortion (120a and Supp. App. 9).

Section 1870.05 establishes two rules to govern the conduct of abortion clinics when dealing with unemancipated minors (119a-120a). In the case of unemancipated minors, ages 15-17, Section 1870.05(A) provides that a physician may not perform an abortion on such minors without utilizing one of two options: if the minor is not accompanied by her parent or legal guardian, (1) the clinic must either notify one of the parents or guardian

of the proposed abortion, or (2) possess a valid judicial consent to the abortion procedure. The Court of Appeals reversed the District Court's holding and upheld the facial validity of this requirement because the plaintiffs were clinics and a physician, rather than a minor, stating: "Until the requirements of Section 1870.05(A) are questioned by a minor who claims to be mature or emancipated or claims that notice would not be in her best interest, we cannot hold this section facially invalid" (13a). The clinics did not appeal this holding and it is therefore not before this Honorable Court.

Section 1870.05(B) provides that at least one parent must be notified and consent to the abortion, or that judicial approval of the abortion be obtained before it is performed when a minor is under the age of fifteen. The record supports the general contention that minors approach the abortion decision seeking adult guidance, approval and moral support (J.A. 129a-131a), and that this contention applies almost universally to minors under the age of fifteen. Each of the experts who testified stated that, because of her immaturity, it was most unlikely that a minor of these tender years could make an adequate decision on her own regarding pregnancy. (See, *e.g.*, J.A. 278a). On the record below, therefore, Section 1870.05(B) applies only to what have been called "immature" minors.

Although the principal plaintiffs in *Bellotti (II), supra,* 443 U.S. 622, 623 (1979), were "unmarried . . . minors who have adequate capacity to give a valid and informed consent," both the District Court and the Court of Appeals relied on that case to hold that the principal parties in this case, abortion clinics operated for profit, could not be forced to notify and obtain the consent of either a parent or a juvenile court prior to performing

an abortion on minors who are not capable of giving a valid and informed consent. The District Court reasoned that the provision of notice to the parents rendered the ordinance unconstitutional (93a) while the Court of Appeals held that *Bellotti (II), supra,* required invalidation of any statute which "provide(s) a possible third party veto" (12a). It did not discuss whether the provision for judicial override of the parental decision was significant or whether it considered a juvenile judge to have an impermissible "third party veto."

It is clear from the trial record that most of the "informed consent" information required to be given by Section 1870.06(B) to a minor and/or her parents is not given unless specifically requested by the patient. The clinics consider the information regarding risks, alternatives available, public services and fetal development to be either harassing, disturbing or irrelevant. Despite the severability clause, Section 1870.19 (129a), the Court of Appeals held that all subsections were unconstitutional, regardless of their content, on the grounds that they "impose" 'restrictions or regulations governing the pregnant woman's attending physician with respect to the termination of her pregnancy, (*Planned Parenthood of Central Missouri v. Danforth*), 428 U.S. at 80'" (15a). Notably, however, the record clearly demonstrates total lack of the true physician-patient relationship envisioned in *Roe v. Wade, supra.* Rather, the abortion clinics in this litigation are commercial establishments which provide abortions "on demand."

a. Counselling and Physician Contact

The record demonstrates that physicians have very little contact with pregnant minors who seek abortions at the clinics. Dr. Bliss, the physician who claimed to

represent the rights of immature minors in the Akron area, lives and practices in Cincinnati, nearly 300 miles away. He only occasionally performed abortions in Akron and only at one of the clinics. In some cases, clinic patients receive tranquilizers before being examined for the first time by the doctor who is to perform the abortion. One of the physicians employed by the clinics has a heavy foreign accent which makes his speech difficult to understand (J.A. 147a). Dr. Bowen, who testified for the clinics regarding the position of the Summit County Medical Society, admitted on cross-examination that such practices were not in accord with his own standards (Tr. V, 61-63), and that he had never looked into the counselling and admitting procedures at the clinics before rendering an opinion on the need for this ordinance (Tr. V, 43-57). All the expert witnesses, even those called by the clinics, made it clear that adequate counselling is more than simply information giving, whether the patient is a minor or an adult, and that it will have and has a positive effect which can minimize most abortion problems (Tr. IV, 89-93; VIII, 20-45; X, 184-198).

Since the primary interest of the Respondent parents is the well-being of their daughters, it is particularly relevant to focus on the type of treatment afforded minors who seek abortions at the clinics in this case. The record makes it clear that the care provided by the clinics does not meet the standards for the treatment of minors described by any of the expert witnesses called at trial. There are therefore no safeguards whatsoever—save this ordinance—which would assure that immature minors receive adequate treatment and information prior to abortion. When coupled with the experts' opinion that few, if any, immature minors (*i.e.*, those under 15

years of age) have the ability to make a truly informed consent, the need for adult guidance by an informed individual concerned with the child's welfare is obvious.

Francene Lucas (whose testimony begins at Tr. VII, 146), a counsellor at Respondent WomenCare Clinic, was typical of the counsellors who appeared before the District Court. She does not have a bachelor's degree, although she did "attend college for approximately two years" (J.A. 251a). She received approximately eight hours of training for what she would be doing in a counselling capacity at the clinic. On various occasions during this eight-hour training period, she spent about an hour in consultation with a doctor (J.A. 252a). She was not required to do any reading of the literature other than that provided in the clinics themselves and was not tested on material she did read (Tr. VII, 165). The record discloses that Ms. Lucas' only previous experience in counselling was "as a respiratory therapist" (J.A. 247a). She spends approximately 15-25 hours per week, both in person and via "telephone counselling," advising women contemplating abortion (J.A. 247a). In the course of a normal business day she spends one to two hours answering the telephone or receiving people as they walk in the door (J.A. 247a-248a). She would conduct two, possibly three, counselling sessions, and 85% of the persons would participate in group counselling (J.A. 248a). Ms. Lucas' general procedure is to speak with each patient individually "for a few moments," and then "take her into the group counselling room" where she would "[give] information about the abortion procedure itself, [and] what [the patient would] expect to experience during and after the procedure." The patient is also told "how much time she will be spending in each area of the clinic, the laboratory, the procedure room,

the recovery room, [and] which personnel members she will have contact with" (J.A. 248a-249a). After this, the patient is given information as to what she may expect for two weeks following the abortion procedure. She also receives follow-up examination information, birth control information, and information about possible complications and hazards that may occur during and after the procedure. She is asked to read the consent form—a package that lists the risks and complications that may be involved—and asked to sign her name (J.A. 249a). Then the patient is put through the group counselling sessions. Only thereafter is the patient introduced to the nurse and doctor (J.A. 249a). Some patients, including minors, may also receive preoperative medication on standing physician orders (librium or valium) before they see the doctor (Tr. VII, 157; J.A. 256a).

Dr. Heald, an expert called by the clinics, testified that ability to consent and "the whole issue of teenage pregnancy is related to age" (J.A. 129a, 132a), but Ms. Lucas stated that, in her understanding, "[it] is not anybody's responsibility there at the clinic to judge the maturity of an under-fifteen-year-old" (J.A. 252a). Since the vast majority of the patients visiting the clinic have visited it only on the day of the abortion (J.A. 253a), and the physician spends only a few minutes with each patient, no one determines whether an immature minor really understands the information she has just received.

Although Ms. Lucas admitted that the fact of pregnancy is relevant to counselling, as is gestational age and birth control information, she did not routinely mention to a patient that there are numerous public and private agencies to assist her during her pregnancy. Information

on fetal development was not considered by any of the clinics to be relevant to the decision to have an abortion (Tr. VII, 169-171). Ms. Lucas felt that it was a "fair statement" to say that her role in counselling a minor was that of "information giving only" (J.A. 254a-255a). By contrast, Dr. Shelly, a psychiatrist with extensive experience, emphasized the need for a much more detailed and personalized approach to counselling (J.A. 282a-284a). All the experts emphasized that minors have special needs, but none of the clinics are staffed to provide for them.

At these clinics minors are forced to participate in group counselling with adults. They receive little personal attention (J.A. 254a-255a), even though the clinics' own expert, Dr. Heald, testified that teenagers tend to be intimidated easily if they are treated as adults. He explained that they are unsure of themselves and do not respond in the same manner as adults because they lack adult coping skills (J.A. 132a-133a). Notwithstanding these special needs, the clinics simply assume that minors, who are frightened and easily inteimidated, are to be treated no differently than adults (J.A. 255a, 155a, 132a-133a). In fact, one clinic even separates a minor from the parent who accompanies her to the clinic if the other group members object (Tr. III, 92; J.A. 155a).

b. Judicial Alternative

The District Court did not hear evidence respecting the nature of the judicial proceeding contemplated by Section 1870.05. Moreover, it did not consider that the contours of the hearing are governed by federal and state constitutional due process requirements. Such requirements specify that, except in emergencies, notice must be given to parents of any hearing which can affect their rights, and that expedited hearings are available

(Supp. App. 1-9). Since Ohio juvenile procedure was not challenged either on its face or "as applied" to abortions for immature minors, the court did not consider why the hearing provided by Ohio law for all medical cases where parental consent is unavailable would be inadequte "as applied" to abortion for an immature minor.

SUMMARY OF ARGUMENT

I. The record in this case demonstrates that only immature minors are affected by Section 1870.05(B) of the Akron ordinance, which requires parental consent or court approval for an abortion of an unmarried minor under 15 years of age. The procedures used in the Akron abortion clinics do not require parental involvement, nor do they ensure that an informed decision is made by the immature minor, but simply assume that she wants an abortion and that abortion is in her best interest. The ordinance provides for a judicial override of a parental veto, and the applicable state judicial procedure was not even challenged by the abortion clinics. Section 1870.05(B) does not unduly burden the abortion decision of an immature, unemancipated minor.

II. The standard of review in abortion-related cases should be clarified by this Court. The Court of Appeals for the Sixth Circuit applied an improper standard which automatically invalidates all substantive abortion regulation applicable to the first trimester of pregnancy. A state must show a compelling interest in support of an abortion regulation only when such regulation unduly burdens the right to seek an abortion, even during the first trimester. Under the facts of this case, the City of Akron nevertheless does have a compelling interest in requiring parental consent for the abortion of an unmarried, immature minor.

ARGUMENT

I.

THIS COURT SHOULD APPROVE THE PARENTAL CONSENT/JUDICIAL ALTERNATIVE PROVIDED BY SECTION 1870.05(B) OF THE AKRON ORDINANCE.

A. The Record Below Demonstrates That Only Immature Minors Are Affected By The Parental-Judicial Consent Provisions Invalidated By The Court Of Appeals And The District Court.

Section 1870.05(B) of the Akron ordinance applies only to minors under the age of fifteen. All experts who testified at trial regarding minors conceded that it was most unlikely that a child of fourteen or under could make an adequate decision on her own regarding her pregnancy (*e.g.*, J.A. 278a). The record amply supports the contention that all minors approach the abortion decision seeking guidance, approval and moral support from adults (J.A. 129a and 131a). The immaturity of the children protected by this ordinance and their reliance on adult opinion should be given great weight by this Honorable Court when it measures the state's interest in assuring that some adult having the child's interest in mind will make the ultimate determination of what is in her best interests. Nevertheless, both the District Court and Court of Appeals removed parental and judicial safeguards designed to assure that an informed adult having the child's best interest in mind will help her decide. Instead, the ultimate decision for these children was left to a financially-interested abortion clinic's staff (not even the physician), which has no experience or special training regarding the medical considerations or the counselling of immature minors, and which

admits to making absolutely no attempt to measure their emotional, moral, physical or psychological maturity.

Respondents Dr. Seguin and Mrs. Black testified that their daughters could be harmed by leaving them at the mercy of a clinic that will profit only if the choice is to abort. Mrs. Black, for example, stated that her desire to be notified prior to an abortion on her daughter was based on her knowledge that she "would lack maturity to make a decision on her own[,]" and "[s]he couldn't possibly . . . be capable of considering all of the side effects of the situation." Mrs. Black also testified that an abortion "would probably hinder her [daughter] physically, mentally, and spiritually, and that she couldn't possibly consider all the sides on her own" (J.A. 232a). Dr. Seguin, a board-certified pediatrician, who testified both as an expert in the care and treatment of minors and as the father of immature, unemancipated, minor daughters of child-bearing age, "felt it was of utmost importance that [h]e as a parent would be knowledgeable of it if one [of his daughters] were to become pregnant, so [that he could] properly [counsel her]" (J.A. 234a-235a). He felt his guidance and support as a parent was needed because he did "not think that at 14, 15 or 16 [his child could] make a mature judgment as to what ought to be done in such a situation" (J.A. 234a-235a). The testimony of the other experts supports him (*e.g.*, J.A. 110a-111a, clinics' expert).

The record also demonstrates that moral views differ over the acceptability of abortion as a "solution" to a problem pregnancy, and that some parents consider this to be a major factor in determining whether an abortion is in their daughter's "best interest." Both Dr. Seguin and Mrs. Black oppose abortion and would seek to reaffirm that moral view with their daughter as part of their

responsibility to instruct her in matters of moral choices should she be faced with the decision of delivery or abortion. By contrast, the clinics feel abortion is generally the answer for a pregnant minor and appear to consider any discussion of the moral perspective either irrelevant or "disturbing." (See, *e.g.*, J.A. 110a.) In their view a child is able to make a major life decision such as abortion if she is able "to state the benefits of not being pregnant in [her] life, and the disadvantages of continuing the pregnancy in [her] life, and in [her] circumstances" (J.A. 144a). Assuming, *arguendo,* that all parties can agree with the abstract proposition that any troubled, pregnant twelve-year-old with normal intelligence can recite some "benefits" of not being pregnant, it should be obvious that such an approach by the clinics begs both the maturity and "best interest" questions. This was not the test of maturity this Honorable Court had in mind when it decided *H. L. v. Matheson,* 450 U.S. 398 (1981), and it is certainly not consistent with the multifaceted inquiry suggested by the Court and the many experts who testified at trial as the key to determining what is "best for a given child.

> Yet an abortion may not be the best choice for a minor. The circumstances in which this issue (i.e. the "best interests") arises will vary widely. In a given case alternatives to abortion . . . may be feasible and relevant to the minor's best interests.

Bellotti v. Baird (II), supra, 443 U.S. at 642.

Nevertheless, such cursory "tests" to determine if the minor wants the abortion are standard operating procedure for these clinics. The "feasible and relevant" alternatives discussed by this Court are considered by the clinics to be irrelevant to the process.

Ironically, the decisions below make it impossible for either a concerned parent or a juvenile court judge to protect the pregnant child from such self-serving pressure tactics by the clinics. Rather, *Bellotti (II)* makes it clear that a case-by-case inquiry is crucial to a determination regarding a pregnant minor's ability to decide, *supra,* 443 U.S. at 643-644 & n.23, and the Akron ordinance seeks to require these clinics to make that inquiry. This Court should not permit *Roe v. Wade, supra,* to be used as an excuse for abortion clinics to provide substandard care for children.

B. The Record Below Indicates That The Counselling Provided Immature Minors Is Inconsistent With Community Medical Standards For The Treatment Of Immature Minors, And The Respondent Clinics Make No Attempt To Distinguish Between A "Mature" And An "Immature" Minor.

The record demonstrates, and all the parties agree, that the abortion decision is a difficult one. It requires time for thought and understanding of the facts. However reached, the decision can have a profound impact on a woman's physical and psychological health in her later life (Tr. X, testimony of Drs. Sim and Shelly). Because knowledge and understanding of possible complications, alternatives, and the biological facts of pregnancy and fetal development will go along toward assuring that the decision to abort is both firm and informed, the physician has a crucial role to play in assisting the patient in making the decision. This is especially true in the case of minors.

Because not every minor, regardless of age or maturity, may give effective consent for an abortion, *Danforth,*

supra, 428 U.S. at 75, it is imperative that some attempt be made to determine whether or not a given minor is capable of making a truly informed consent. To date, the Court's decisions have recognized this point, but have focused almost entirely upon protecting the choice options of those whose maturity makes it unnecessary for another to make the decision for them. *See, e.g., Bellotti (II), supra*; *Danforth, supra.*

In this case, however, the principal focus is upon minors who, because of their youth, are incapable of making the decision on their own (J.A. 278a). Once this inability to decide has been established, the question is no longer one which focuses on protecting the decision-making process, but rather upon who will be entrusted with the responsibility of making the decision in the first place. Once this is clearly understood, it becomes rather apparent that, if treated as an adult, the immature minor becomes merely a subject of treatment rather than an active participant in the process.

The unfortunate effects of treating immature minors as if they were adults is readily apparent in the assembly-line process utilized by the clinics in this case. The "counsellors" are unqualified to counsel immature minors and ignore the patently coercive effects of including children in group sessions with adults (J.A. 225a-226a; 130a (noting minors' susceptibility to pressure)). They have no special training which would assist them in determining the maturity level of a given minor (Tr. I, 226; II, 27-29; J.A. 118a) and make no real effort to do so in any event. Dr. B, a physician employed by one of the clinics, testified:

> Q: Do you make any attempt to judge the maturity of the patient?

A: What do you mean "maturity"? Can you explain it to me? I don't understand what do you mean by "maturity". Do you mean, the patient or the—

Q: I am speaking of the maturity of the patient, yes.

A: No.

(J.A. 245a-246a)

Ms. Goldberger, director of the Akron Women's Clinic, Inc., testified that her clinic wishes to maintain a pregnant woman's "feeling of well-being at the clinic and her feeling of well-being with the decision" (J.A. 143a). Even in the case of immature minors, the clinics simply assume that the decision to abort has been made prior to arrival at the clinic and seek to maintain that "decision" (whether or not it has really been made) by avoiding discussion of topics which are essential if the physician is to determine whether the decision is informed (Tr. VI, 121-122). For an immature minor incapable of making the decision on her own, the failure to discuss the "informed consent" factors identified by this Court in *H. L. v. Matheson, supra,* 450 U.S. at 400 n.1 (identifying available adoption services, fetal development and foreseeable complications and risks of abortion), reduces the decision-making process to nothing more than a determination that the girl desires an abortion (*cf. Matheson, supra,* 450 U.S. at 403-404 & n.8). Because the clinics admit that they lose their fee if the decision is not to abort, the decisions below allow adults whose financial interests are in conflict with the best interests of the child to make the choice for her.

C. A State-Imposed Requirement Of Parental Consent Coupled With A Provision For Judicial Override Does Not Violate The Rights Of An Immature, Dependent Minor And Is Consistent With Community Medical Standards For The Treatment Of Minors In The Absence Of Parental Consent.

1. *The Record In This Case Establishes The Respondent Clinics Simply Assume That A Minor Wants An Abortion If She Visits Their Facilities.*

The clinics made it clear at trial that they use counselling as a means to support the assumed decision of the prospective patient to abort. In the case of an immature minor, all the witnesses agreed that no knowledgeable decision can be made by the child alone. Nevertheless, these clinics object to parental or judicial involvement in the decision-making process because they feel that abortion is a perfectly "acceptable" moral alternative which is always in the "best interests" of an immature minor (J.A. 226a-227a, "Typically, we enter into a discussion . . . and this certainly includes what she feels is best in her conscience and life"; J.A. 118a, parents included only when they agree that abortion is best alternative; Tr. III, 121, witness felt "fairly pro-abortion for very young teenager"). By contrast, Dr. Seguin, a parent with minor daughters as well as a board-certified pediatrician and professor of clinical pediatrics at the Northern Ohio College of Medicine (Tr. III, 54), testified that it is wholly inappropriate to make any assumptions about either what is "best" for an individual minor patient or what she is capable of understanding without assistance from a parent or other adult (J.A. 235a-237a).

His view is in accord with that expressed by several members of this Court who have rejected the argument that "the opinion of a single physician as to the need or desirability of an abortion outweighs all state and parental interests." *Matheson, supra,* 450 U.S. at 419-420 (footnote omitted) (Powell and Stewart, J.J., concurring). Where, as here, the physician has little, if any, contact with or concern for the individual needs of abortion clinic patients, the casual approach to the treatment provided by the clinics is altogether apparent. Dr. C., a physician employed by one of the clinics, confirmed this view.

> A. Again, if she was already at the clinic, she's there for one purpose. She's already gone through all the steps to get to the clinic. She's already made her own decisions as to what to do with that pregnancy.
>
> Q. Are you saying, Doctor, then when an individual comes to the clinic she has made up her mind to have the abortion?
>
> A. Sure; when you go to a bar, you go there to drink.

(J.A. 231a-232a)

2. *Judicial Override/Consent For Necessary Medical Care Is Common Practice In Cases Where Parental Consent Is Withheld Or Otherwise Unavailable.*

The degree to which the clinics in this case have sought to insulate themselves from standards commonly applicable to others who treat minors without the benefit of parental consent or involvement is readily apparent from the record. Rather than to frankly admit, as did one of their witnesses, that they feel that abortion is generally

the treatment of choice for a pregnant minor (Tr. III, 121), the clinics claim to assert the right of the minor to decide, in consultation with her physician, to have an abortion. *See Danforth, supra,* 428 U.S. 52 (1976); and *Singleton v. Wulff,* 428 U.S. 106, 118 (1976). In the case where immature, pregnant minors are involved, however, such an approach falls far short of the minimum inquiry required for adequate consideration of the interests of the child, her parents, and the state. Where, as here, the clinic has no more than a bare financial interest in the performance of the abortion and there is no time for the child to form a physician-patient relationship with a clinic physician, it is highly questionable whether the clinic or clinic physician should be permitted to argue the child's rights.

Because "[t]here is no logical relationship between the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion," *Matheson, supra,* 450 U.S. at 408, it is fallacious to argue that an immature minor has the "right" to make a decision to abort "in consultation" with a clinic physician who sees her if she has any questions, and then performs the abortion (J.A. 228a). There is neither a consultative relationship with the physician, nor the capacity for mature judgment the decision demands (J.A. 278a). Since it goes without saying that someone other than the minor must then form a relationship with the physician in order to determine whether an abortion is the best form of treatment under the circumstances, this Honorable Court must determine who that third party is to be.

In virtually all other cases the responsibilty for the medical care of a child is borne by the parents. When they fail or refuse to carry out this duty, Ohio law

mandates state involvement. *See* Ohio Rev. Code Secs. 2151.03, 2151.23, 2151.28, 2151.281, 2151.33, and 2151.421 (Supp. App. 1-4; 140a). Because all parties to this proceeding claim to assert the "best interests" of the pregnant minor, it is necessary to examine the claims of each carefully. Only then can it be seen that the interests of the clinics are purely financial.

The interests of the state are threefold. First, the state has an interest "in fostering such consultation as will assist the minor in making her decision as wisely as possible." *Danforth, supra,* 428 U.S. at 99. Second, the state has an interest in preserving the integrity of a functioning family unit. *See Santosky v. Kramer,* ___ U.S. ___, 71 L. Ed. 2d 599 (1982); *Moore v. City of East Cleveland,* 431 U.S. 494 (1977). Finally, the state has an interest in protecting children from neglect and abuse by any person by providing for judicial and administrative remedies. *See* generally, Ohio Rev. Code Chap. 2151. Under Ohio law, no child is to be left without adequate medical treatment, and judicial remedies are available at the request of any person having knowledge of a child's need for medical care. Ohio Revised Code Sec. 2151.27 permits "[a]ny person" having knowledge of a child's medical need to "file a sworn complaint in the juvenile court" (Supp. App. 4). This section, taken together with the duty imposed upon all medical personnel, attorneys, teachers, social workers and other social service professionals to report all suspected cases of neglect or abuse to the appropriate authorities "forthwith" (Ohio Rev. Code Sec. 2151.421) makes it clear that the focus of Ohio law is on the best interests of the child (140a).

The interests of the parents and family of the immature minor are interests which are substantially identical

to those of the state, but with one important exception: the family is "the institution by which 'we inculcate and pass down many of our most cherished values, moral and cultural.'" *Bellotti (II), supra,* 443 U.S. at 634, quoting *Moore, supra,* 431 U.S. at 503-504 (plurality). As this Court noted in *Bellotti (II), supra,* the state is bound to defer to parental control over children unless there is compelling need for state intervention. 443 U.S. at 633-634, 638.

> [A]n additional and more important justification for state deference to parental control over children is that "[t]he child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." *Pierce v. Society of Sisters,* 268 U.S. 570, 535 (1925). "The duty to prepare the child for 'additional obligations' . . . must be read to include the inculcation of moral standards, religious beliefs, and elements of good citizenship." *Wisconsin v. Yoder,* 406 U.S. 205, 233 (1972). This affirmative process of teaching, guiding and inspiring by precept and example is essential to the growth of young people into mature, socially responsible citizens." *Bellotti (II), supra,* 443 U.S. at 637-638.

In this case, parental interests are represented by parents who believe that abortion would not be a proper choice for their immature minor daughters. When parents such as Dr. Seguin and Mrs. Black do not share the view of clinic experts who feel "fairly pro-abortion for young teenagers" (Tr. III, 121), clinics such as these at bar simply exclude them from the process (J.A. 118a). The *betes noires* allegedly warranting parental "bypass"—obstructionism, child-abuse, suicide, self-abortion and family strife—are relied upon by the clinics to exclude

any parental input whenever a parent may disagree with the choice of abortion. *See, e.g., Bellotti (II), supra,* 443 U.S. at 647; *Bellotti v. Baird,* 450 F. Supp. 997, 1000-1001 (D.C. Mass. 1978). Respondents submit, however, that such practices are precisely the reason why the state has enacted laws protective of children and made it so easy to invoke the protective power of the juvenile court or children's services agencies. *See* Ohio Rev. Code Secs. 2151.23, 2151.27, 2151.28, 2151.281, and 2151.421 (Supp. App. 1-4; 140a). As parents, their interests in the welfare of their children are, if anything, stronger than that of the state, and certainly stronger than any interest the clinics may have.

> *Lassiter* [*v. Dept. of Social Services,* 452 U.S. 18 (1981)] declared it "plain beyond the need for multiple citation" that a natural parent's "desire for and right to 'the companionship, care, custody, and management of his or her children'" is an interest more valuable than any property right.

Santosky, supra, ___ U.S. ___, 71 L. Ed. 2d at 610.

For this Honorable Court, or any other agency of the state, to assume – without the benefit of credible evidence – that parents will abuse their child if they learn that she has become pregnant flies in the face of this Court's statement that "there is no reason to believe the overall welfare of a minor can be equated with that of most parents." *Matheson, supra,* 450 U.S. at 419-420 n.8 (Powell and Stewart, J.J., concurring). *See also Santosky, supra*; *Parham v. J.R.,* 442 U.S. 584 (1979); *Quilloin v. Wolcott,* 434 U.S. 246 (1978); *Ginsberg v. New York,* 390 U.S. 629 (1968); *Wisconsin v. Yoder, supra*; *Pierce v. Society of Sisters, supra.*

Dr. Seguin testified that standard medical practice in Akron in cases where abuse is suspected is for the

physician to seek protection for the child through the juvenile court. Only then are the parents notified that treatment is being considered (J.A. 239a). Such practice recognizes the child's needs as well as the interests of the parents without sacrificing either.

By contrast, the clinics care little for the needs of the child. Children are routinely treated as if they were adults; no attempt is made to determine their level of maturity or understanding; and no attempt is made to protect a child from abusive parents once she leaves the clinic. Their concern is purely financial; for they do not even report suspected abuse cases to the authorities as required by law (J.A. 154a). *See* Ohio Rev. Code Sec. 2151.421 (140a). Clinic policy is not to be supportive of the child's best interests and welfare. Rather, it is to be supportive of a decision to have an abortion, the only one which will result in payment for the clinic. The effect of such procedure where an immature minor is involved is to permit unqualified clinic personnel having no experience in the treatment of minors and a financial stake in the choice of abortion to make the choice for her. What she really wants or needs is irrelevant; the clinic simply assumes that, once she consults them, she has made her decision.

In *Danforth, supra,* 428 U.S. 52 (1976), Mr. Justice Stewart observed in footnote 2 the clinic operation in *Bellotti (I), supra*:

> The counseling . . . occurs entirely on the day the abortion is to be performed. . . . It . . . takes place in groups that include both minors and adults who are strangers to one another. . . . The physician takes no part in this counseling process. . . . Counseling is typically limited to a description of abortion procedures, possible complications, and birth control techniques. . . .

> The abortion itself takes five to seven minutes.... The physician has no prior contact with the minor, abortions are being performed at the [clinic], the physician . . . may be performing abortions on many other adults and minors. . . . On busy days, patients are scheduled in separate groups, consisting usually of five patients. . . . After abortions, [the physician] spends a brief period with the minor and others in the group in the recovery room. . . .

428 U.S. at 91-92

He could have taken the facts directly from the record in this case. Unlike other medical practice, no fee is charged unless the patient decides to have an abortion, giving the clinic and physician a vested interest in the minor choosing abortion. If a minor decides not to undergo an abortion, the clinic loses income, and the physician, paid on a per-patient basis, loses his fee (J.A. 220a, 223a, 215a, 228a and 241a). With fewer questions asked and less information disseminated (J.A. 232a-233a), the decision to abort is a virtual certainty. An immature minor, with her "feelings of well-being" enhanced by a dose of valium or librium (Tr. VI, 26-27; J.A. 147a, 226a and 232a), will be docilely led in and out of an operating room by strangers. There she is supposed to establish, five minutes or so before her abortion, a "physician-patient" relationship with another stranger—this time a doctor—who may not even speak English well enough to make himself understood (J.A. 241a-245a). Should she develop complications after leaving the clinic, she must either find another doctor or tell her parents anyway. Dr. Bliss, who purports to represent her rights in this case, sees his patients in Cincinnati, nearly 300 miles away!

It is this physician-patient "relationship" on which the Court of Appeals relied to invalidate the alternative

parental/judicial consent provisions for immature minors provided by Section 1870.05(B). Because of its mechanistic concern for a possible "third-party veto," the Court of Appeals ignored both the fact that this ordinance protects young children, not adults, and that a judge's decision was not the type of impermissible "third-party veto" this Court held invalid in *Danforth, supra,* and *Bellotti (II), supra.*

D. The Clinics Did Not Challenge The Adequacy Of The Judicial Alternative To Parental Consent For Immature Minors Provided By Chapter 2151 Of The Ohio Revised Code.

The Court of Appeals invalidated Akron's parental/judicial consent option for immature minors because "'the unique nature and consequences of the abortion decision' . . . make it inappropriate, on the basis of deference to parental rights, to provide a possible third-party veto over the decision of the pregnant woman and her doctor to terminate her pregnancy" (12a, citing *Bellotti (II),* 443 U.S. at 643). The fallacy of this rationale is immediately apparent on examination. First, no minor, mature or immature, challenged this provision. As Judge Kennedy pointed out in her dissent:

> Section 1870.05(B) is capable of a construction that would render it constitutional. This would be the case if, for example, the order from "a court having jurisdiction" was based, as it constitutionally must be, first on an inquiry into the minor's maturity. Thus, the section is not facially invalid. As the majority notes in reversing the District Court's holding that section 1870.05(A) is unconstitutional, no minor challenges the Akron ordinance. I would not find section 1870.05(B) unconstitutional until

a mature minor challenges it and until it has been construed by a lower court.

(33a)

Second, there is no doctor-patient relationship involved here. Judge Kennedy noted in dissent "that the doctors at Akron Center's clinic did little, if any, counselling before seeing the patient in the procedure room" (36a). Because of the immaturity of girls 14 years of age and under it is doubtful that they can even form the sort of relationship contemplated by this Court in *Roe v. Wade, supra.* Where the contact is as short as it is here, it is ludicrous to assert that a "relationship" exists.

Third, no "third-party veto" of a woman's "decision" is involved when, as here, the minor is inherently incapable of making the decision on her own. If a child lacks the ability to make a meaningful informed consent, the question for the court is: "Who shall decide, if not the child herself?" Based upon the record and judicial notice of the maturity of minors under 15, the appellate court should have found that such minors are immature as a matter of law.

The Court of Appeals did not identify the "third party" whose "veto" rendered Section 1870.05(B) unconstitutional. The parents have no veto, for a judicial override is available under the Ohio juvenile court law. Since "all members of [this] Court agreed that providing for decision-making authority in a judge was not the kind of veto power held invalid in *Danforth,*" *Bellotti (II), supra,* 443 U.S. at 650-651, the alleged defect in the ordinance has not been identified by the Court of Appeals.

In *Bellotti (II), supra,* this Court, in a divided opinion with no majority, indicated that it would be unconstitu-

tional for a state to require parental notice of a proposed abortion prior to a mature minor's attempt to invoke the power of a juvenile court to consent to an abortion because the parents might prevent the minor from going to court, 443 U.S. at 642-648, but in the *H. L. v. Matheson, supra,* a "pure" notice statute was approved. Unlike the state laws at issue in *Bellotti (II)* and *Matheson,* the Ohio law which would govern the judicial consent procedure has nothing to do with abortion. It was not challenged below, either on its face or "as applied" to abortions. Ohio Rev. Code Chapter 2151 governs the procedure of all juvenile proceedings in the State of Ohio, including cases of alleged medical need, and reflects a procedural due process requirement of notice prior to state action which can have an adverse impact upon important personal rights and interests. *See Goldberg v. Kelly,* 397 U.S. 254 (1970); *In re Gault,* 387 U.S. 1 (1967). The District Court, however, found Section 1870.05(B) unconstitutional without first determining whether the Ohio juvenile procedures comport with the standards of *Bellotti (II), supra.*

In *Danforth, supra,* this Court found a Missouri statute requiring parental consent prior to abortion unconstitutional because it left the parents with an "absolute veto" over a minor's decision to have an abortion. Section 1870.05(B) does not provide anyone with an "absolute" (*i.e.,* unreviewable and possibly arbitrary) veto. It applies only to minors whose ability to make such a decision is highly questionable and provides for judicial consent where the parents are either unavailable or refuse consent. *Bellotti (II), supra,* requires no more.

> We therefore conclude that if the State decides to require a pregnant minor to obtain one or both parents' consent it must provide an alternative pro-

cedure[23] whereby authorization for the abortion can be obtained. . . .

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[23] . . . we discussed the alternative procedure described in the text in terms of judicial proceedings. We do not suggest, however, that a State choosing to require parental consent could not delegate the alternative procedure to a juvenile court. . . .

Bellotti (II), supra, 443 U.S. at text and n.23.

The gravamen of the clinics' problem with Section 1870.05(B), therefore, is not that it provides a "veto," but that it provides for a disinterested forum as contemplated by the express language of *Danforth* and *Bellotti (II).* The clinics' position is perfectly consistent with their practice: since they assume that an immature minor's best interests are always served by an abortion, there is no need to raise either of the questions thought to be relevant by this Court. Thus, any questioning of the clinics' motives or their assumptions regarding either maturity or "best interests", by parent, guardian or juvenile judge, is seen as an impermissible "third-party veto" of a "woman's" decision. Petitioners respectfully submit that this is not the sort of veto this Honorable Court had in mind.

II.

THE STANDARD OF REVIEW IN ABORTION-RELATED CASES SHOULD BE CLARIFIED BY THIS COURT.

A. The Standard Of Review In Abortion-Related Litigation Is Unclear And Leads To Conflicting And Illogical Results.

Since this Court's decision in *Roe v. Wade, supra,* there has been considerable confusion among courts and commentators concerning the appropriate standard of review to be applied in abortion-related cases. *Compare, e.g., Abortion Coalition of Michigan, Inc. v. Michigan Dept. of Public Health,* 426 F. Supp. 471 (E.D. Mich. 1977) (upholding sanitation regulations as applied to first-trimester abortion facilities), with, *e.g., Friendship Medical Center v. Chicago Bd. of Health,* 505 F.2d 1141 (7th Cir. 1974), *cert. den.,* 420 U.S. 997 (1975) (striking down sanitation regulations applied to first-trimester abortion facilities). The result has been a plethora of litigation with some of the more complex cases and issues reaching this Court more than once. *E.g., Bellotti (I)* and *(II), supra*; *Harris v. McRae,* 448 U.S. 297 (1980).

The reason for much of the confusion relates to the seemingly absolute nature of the language in *Roe v. Wade* implying that all first-trimester regulation, regardless of its asserted justification, is constitutionally impermissible. 410 U.S. at 163-164. As a result, maternal health-based regulations which by their nature cannot possibly infringe on the woman's right to decide to have an abortion (*e.g.,* the "free-standing surgical out-patient" regulations held valid in *Abortion Coalition of Michigan, supra,* but invalidated in *Friendship Medical Center, supra*) have been invalidated on the basis of this Court's essentially unlitigated factual conclusion that first-

trimester abortions are as safe as childbirth. *Roe, supra,* 410 U.S. at 164.

As a justification for a standard of review which focuses on the positive or negative effects on the decision to abort (*i.e.*, whether the regulation restricts or broadens safety and/or available choice-influencing factors or information), such a rationale arguably has merit. *Cf.*, *Matheson, supra* (setting out choice-enhancing factors); *Danforth, supra* ("informed consent" upheld); *Bigelow v. Virginia,* 421 U.S. 809 (1975) (restriction of available information on abortion held invalid). As a justification for an unfocused, across-the-board rationale which would invalidate regulations intended to ensure maximum safety and range of choice, the safety-of-first-trimester abortions rationale of *Roe* makes no sense at all. The entire thrust of *Roe, supra,* and *Doe v. Bolton, supra,* was to ensure that, within limits, abortion was an available choice for women and treated like any other medical procedure. *See Doe, supra,* 410 U.S. 179 (1973); *Maher v. Roe,* 432 U.S. 464 (1977) (recognizing limits to this rationale because abortion is only medical procedure which involves taking of "potential" human life). It is the confusion over the appropriate standard of review to be applied in abortion cases which has resulted in the invalidation of provisions which do nothing more than treat abortion like any other medical procedure, and the result in this case should convince the Court that its assistance is needed to resolve the matter.

B. The Standard Of Review Applied By The Sixth Circuit Court Of Appeals For First-Trimester Abortion Regulation Was An Improper Standard Which Has Never Been Ennunciated By This Court.

In the case at bar, the 2-1 majority of the Sixth Circuit panel held that a two-step analysis is required to determine (1) whether the challenged regulation causes a "legally significant impact or consequence" on the right to terminate her pregnancy (*i.e.*, not *de minimus* or "slight") and, if so, (2) whether the regulation is supported by a "compelling state interest" (7a, 9a). The court stated that if the state has a compelling interest, then and only then should the trial court determine whether or not the regulation imposes an "undue burden" (9a). However, the court then asserted that, since "the state has no compelling interest in the first trimester of pregnancy," any regulation therein which results in a "legally significant impact or consequence" is impermissible (10a). Thus, this test is actually no test at all but simply a blanket invalidation of all first-trimester regulation.

Judge Cornelia Kennedy's well-reasoned dissent from the majority holding below disagreed:

> Because I am less certain than the majority that the Supreme Court's abortion decisions call for such a two-step analysis, I am not able to concur with the panel even though I do not completely agree with the District Court either. (25a)
>
> * * *
>
> Thus, the Supreme Court has never suggested the analysis put forth by the majority. It has sometimes suggested that a compelling state interest is necessary to justify any state regulation of abortion

during the first trimester, but the language has always been far broader than required by the facts before it. With the exception of the passage in *Colautti, supra,* and a part of *Planned Parenthood,* all of the cases since *Roe* have suggested that the proper standard is simply whether a regulation that does not effectively prohibit abortions is "unduly burdensome" to the decision whether or not to abort. (32a)

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[5] . . . The Seventh Circuit's concern that plaintiffs who must challenge abortion regulations on other than an across-the-board "compelling state interest" standard will be unable to anticipate the state's possible justifications for the regulations simply does not ring true in the abortion context. Nor do I share the Seventh Circuit's concern that the courts are incapable of determining when a burden on the abortion decision is "undue." (32A)

(Note 5, referring to *Charles v. Carey,* 627 F.2d 772, 777-778 (7th Cir. 1980))

When applying this test to Section 1870.05(B), the parental consent requirement, the Sixth Circuit necessarily had to find that provision unconstitutional, since it applies to the first trimester of pregnancy, without any consideration of its reasonableness or burden (11a, 12a). The Court totally disregarded the fact that *Bellotti (II), supra,* 443 U.S. at 640-641 (1979), approved such a parental consent requirement with a judicial override.

C. A State Must Show A Compelling Interest In Support Of A Duly Enacted Abortion Regulation Only When Such Regulation Has Been Shown To Be Unduly Burdensome On The Right To Seek An Abortion, Even During The First Trimester Of Pregnancy.

Although this Honorable Court had ostensibly prohibited all first-trimester abortion regulation in *Roe v. Wade, supra,* such was shown in subsequent decisions not to be the case so long as the regulation was not "unduly burdensome" on the abortion decision. *Cf., e.g., Connecticut v. Menillo, supra,* 423 U.S. 9 (1975) (licensed physician requirement); *Bellotti (I), supra* (parental consent); *Danforth, supra* (informed consent, record-keeping, reporting); *Harris v. McRae,* 448 U.S. 297 (1980) (abortion funding); *Maher v. Roe,* 432 U.S. 464 (1977) (Medicaid). In *Bellotti (II), supra,* 443 U.S. at 640, speaking for the plurality, Mr. Justice Powell stated: "The question before us—in light of what we have said in the prior cases—is whether [the regulation] does not unduly burden the right to seek an abortion." Likewise, in *Matheson, supra,* Mr. Justice Stevens noted: "The fact that a statute may have some impact upon a minor's exercise of her rights begins, rather than ends, the constitutional inquiry. Once the impact is identified, it must be evaluated in light of the state's interests underlying the statute." 450 U.S. at 421 (Stevens, J., concurring).

Review of the decisions of this Honorable Court demonstrates that even first-trimester regulation is permissible where either (1) there is no undue burden on the abortion decision, or (2) even if there is an undue burden, the state can demonstrate that such burden is justified by a compelling state interest. However, this

has never been clearly and comprehensively ennunciated in any of this Court's decisions in order to give the lower courts a "unified field theory" of abortion regulation to provide guidelines regardless of the nature, extent or trimester of regulation. The many issues presented and types of provisions contained in the Akron ordinance offer the Court such an opportunity. The facts of this case demonstrate that the parental consent and informed consent provisions of the Akron ordinance would not be unduly burdensome on the right of a pregnant, immature minor or woman to obtain an abortion.

D. The Facts Of This Case Compel The Conclusion That The City Has A Compelling Interest In Assuring An Informed Consent For All Women Seeking Abortions, And That This Interest Is Greatly Magnified In Cases Involving Unemancipated, Immature Minors.

In *Roe v. Wade, supra,* this Honorable Court recognized that the right to an abortion is not unqualified and must be considered against important state interests in regulation. 410 U.S. at 154. That right was abridged because this Court found no compelling state interest to justify absolutely prohibiting a woman and her physician from deciding that abortion is the best course of action for her. The Court emphasized in *Roe* that the abortion decision is to be made in consultation with the woman's responsible attending physician. 410 U.S. at 153, 163-165.

The majority of the Court below, over Judge Kennedy's dissent, has ruled as a matter of law that the state has no compelling interest during the first trimester and has effectively sanctioned the removal of the attending

physician from the process while claiming to rely on the privacy of the physician-patient relationship as its rationale. If the physician is only marginally (or not at all) involved in the decision-making process, as the facts of this case show, the entire physician-patient rationale of *Roe* fails, for there is no consultative physician-patient relationship to protect. The right of privacy in *Roe* lies not in the right of personal autonomy or self-determination, but in the privacy of the physician-patient relationship. In *Menillo, supra,* the Court upheld a requirement that an abortion be performed only by a licensed physician. The Court concluded that the insufficiency of the state's interest in maternal health in the first trimester was predicated upon the fact that the abortion would be performed by a physician under conditions ensuring maximum safety for the woman, stating:

> Even during the first trimester of pregnancy, therefore, prosecutions for abortions conducted by non-physicians infringe upon no realm of personal privacy secured by Constitution against state interference.

423 U.S. at 11.

Throughout the course of its decisions since *Roe,* the Court has clearly envisioned a legitimate physician-patient relationship where women troubled by an unwanted pregnancy receive the advice, support and quality medical care they need to assure a reasoned and informed choice, not a production line where medical responsibilities are deferred to unqualified lay employees. Thus, requiring that the physician personally inform the pregnant woman of relevant medical facts, the risks associated with her pregnancy, the abortion technique to be employed, and other information which seeks to assure that

the choice is truly informed can hardly be considered "unduly burdensome." This is *a fortiori* true where the patient is 14 years of age and under. Common sense should dictate that such activity should be encouraged and, if necessary, required where it does not exist. "Strict scrutiny" simply serves no purpose unless it can be shown with some clarity that the challenged regulation is intended to restrict a woman's freedom of access to abortion. However, even if strict scrutiny were applied to the parental consent and informed consent requirements of the Akron ordinance, the facts of this case demonstrate that the state (City) has a compelling interest during the first trimester.

The basic consultative function of the physician is providing information as to physical and medical facts regarding pregnancy and abortion, risks, options and aftercare. In conjunction with good medical technique, that function promotes the important interest of the state in protecting the woman's health, regardless of the stage of pregnancy. It is, in fact, the very basis of the asserted "safety" rationale of *Roe*. In the case at bar, Dr. Myre Sim of the Royal Canadian Hospital in Ottawa, an expert in the psychiatric and physiological care of abortion and maternity patients for many years, testified that he did not think that anyone but the doctor himself should give the necessary information, and that such is the general medical practice (Tr. VIII, 15, 48). By contrast, the testimony of abortion clinic counsellors and physicians demonstrates complete abdication of this responsibility to the women in their care, a point not lost on Judge Kennedy. Her dissent aptly points out that "[t]he evidence presented at trial showed that the decision . . . was made not by the woman in conjunction with her physician but by the woman and lay employees of the abortion clinic, the income of which is dependent

upon the woman's choosing to have an abortion. . . . Akron's ordinance simply takes into account these realities of the 'physician-patient' relationship at an abortion clinic" (36a).

In stating in *Roe* that the "compelling" point of the state's interest with respect to maternal health does not begin until the end of the first trimester, *see, e.g.*, 410 U.S. at 163, this Honorable Court has misplaced the focus as to the protection of the right of the woman's privacy. Certainly, the state's interest in the health of women is just as great during the first trimester as it is thereafter. That is what is tacitly recognized in *Menillo, supra.* The real issue is the extent to which the state may go to vindicate its interest as weighed against the woman's right of privacy. The premise that "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth," *Roe, supra,* 410 U.S. at 163, assumes that the conditions under which the abortion is performed meet some kind of minimum medical standard. Even the licensed physician-abortionist may be performing abortions under conditions which would otherwise characterize him as a "backalley butcher." The degree of the state's interest should not be predicated solely on "present medical knowledge," *id.*, at 163, but the conditions under which abortions are actually being performed. This extends to the state's interest in assuring an informed consent as well. The constitutional right to an abortion is certainly no greater than the right not to have an abortion. What is protected by the Constitution is that choice. The state's interest extends to ensuring informed consent, *see Danforth, supra,* 428 U.S. at 67, and protecting parental rights, *see Bellotti (II), supra,* 443 U.S. at 637, as well, and is likewise no less compelling during the first trimester. Where the conditions under which abortions

are being performed do not in fact ensure informed consent, especially of an immature minor, or vindicate the "guiding roll of parents in the upbringing of their children," *see Bellotti (II), supra,* 443 U.S. at 637, the state has a compelling interest throughout the woman's (or girl's) pregnancy in the enactment of reasonable regulations to secure these countervailing rights. The evidence in this case clearly demonstrates that abortions are performed on immature minors without deference to the rights of the minors to make an informed choice or the rights of parents to have input in the abortion decision, all accomplished with a total absence of a physician-patient relationship.

CONCLUSION

For the foregoing reasons Respondents Francois Seguin, M.D. and Patricia K. Black respectfully move that this Honorable Court reverse the decisions of the Court of Appeals for the Sixth Circuit and the District Court for the Northern District of Ohio declaring Sections 1870.05(B) and 1870.06(B) and (C) of the Codified Ordinances of the City of Akron, Ohio to be unconstitutional.

Respectfully submitted,

ALAN G. SEGEDY (Counsel of Record)
SEGEDY, UMBAUGH & SHARP
Law & Commerce Building
40 E. Mill Street (at Main)
Akron, Ohio 44308
(216) 253-5535

AND

ROBERT A. DESTRO
School of Law
Catholic University of America
Washington, D.C. 20064
(202) 635-5144

AND

DAVID G. UMBAUGH
SEGEDY, UMBAUGH & SHARP
Law & Commerce Building
40 E. Mill Street (at Main)
Akron, Ohio 44308
(216) 253-5535

Attorneys for Respondents, Francois Seguin, M.D. and Patricia K. Black

SUPPLEMENTAL APPENDIX

TABLE OF CONTENTS

The following materials required by Rule 34.1(f) may be found as follows in the separately-bound Appendix filed on behalf of Petitioner City of Akron in *City of Akron v. Akron Center for Reproductive Health, Inc.*, No. 81-746:

Page

Decision of the United States Court of Appeals for the Sixth Circuit, dated June 12, 1981 . . . . . 1a

Judgment of the Court of Appeals, dated June 12, 1981 . . . . 37a

Order Denying Plaintiff's Motion for Rehearing, dated July 22, 1981 . . . . . 39a

Order Denying Defendant-Intervenors Motion for Rehearing, dated July 22, 1981 . . . . . 41a

District Court Memorandum Opinion and Order, dated August 22, 1979 . . . . . 43a

Order and Opinion of District Court on motion for New Trial, dated October 4, 1979 . . . . . 107a

Order of District Court, dated February 27, 1980 . . . . . 112a

Chapter 1870 of the Codified Ordinance of the City of Akron, Ordinance 160-1978 . . . . . 115a

Selected Sections of Chapter 2151, Ohio Revised Code 130a

Selected Rules from Ohio Rules of Juvenile Procedure 146a

The following additional statutes and ordinances are provided in this Supplemental Appendix for the Court's convenience and are designated as (Supp. App. ___).

Page

Ohio Revised Code:

Sec. 2151.03, "Neglected child" defined . . . . . Supp. App. 1

Sec. 2151.031, "Abused child" defined. . . . . Supp. App. 1

Sec. 2151.23, Jurisdiction of Juvenile Court . . . Supp. App. 1

Sec. 2151.27–Complaint . . . . . Supp. App. 1

Sec. 2151.28–Summons . . . . . Supp. App. 2

Sec. 2151.281, Guardian ad litem . . . . . Supp. App. 3

Sec. 2151.33, Temporary care; emergency medical treatment; reimbursement . . . . . Supp. App. 4

Codified Ordinances of The City of Akron, Ohio:

Section 1870.05, Notice and Consent . . . . . Supp. App. 5

Section 1870.06, Informed Consent . . . . . Supp. App. 5

RELEVANT STATUTORY PROVISIONS

Ohio Revised Code, Sec. 2151.03,
"Neglected child" defined.

As used in sections 2151.01 to 2151.54, inclusive, of the Revised Code, "neglected child" includes any child:

* * *

(C) Whose parents, guardian, or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals or well being;

* * *

Ohio Revised Code, Sec. 2151.031,
"Abused child" defined.

(A) Is the victim of "sexual activity" as defined under Chapter 2907. of the Revised Code, where such activity would constitute an offense under that chapter, except that the court need not find that any person has been convicted of the offense in order to find that the child is an abused child.

* * *

Ohio Revised Code, Sec. 2151.23,
Jurisdiction of juvenile court.

(A) The juvenile court has exclusive original jurisdiction under the Revised Code:

(1) Concerning any child who on or about the date specified in the complaint is alleged to be a juvenile traffic offender, delinquent, unruly, abused, neglected, or dependent.

* * *

(E) The juvenile court has jurisdiction to hear and determine the case of any child certified to the court by

any court of competent jurisdiction if such child comes within the jurisdiction of the court as defined by this section. (Emphasis added)

Ohio Revised Code, Sec. 2151.27–Complaint.

Any person having knowledge of a child who appears to be a juvenile traffic offender or to be delinquent, unruly, abused, neglected, or dependent may, with respect to such child, file a sworn complaint in the juvenile court of the county in which such child has a residence or legal settlement, or in which such traffic offense, delinquency, unruliness, abuse, neglect or dependency occurred. Such sworn complaint may be upon information and belief, and in addition to the allegation that the child is delinquent, unruly, abused, neglected, dependent, or a juvenile traffic offender, the complaint must allege the particular facts upon the allegation of delinquency, unruliness, abuse, neglect, dependency, or juvenile traffic offender is based.

* * *

Ohio Revised Code, Sec. 2151.28–Summons.

(A) After the complaint has been filed, the court shall fix a time for hearing, which if the child is in detention, shall not be later than ten days after the filing of the complaint. It shall direct the issuance of a summons directed to the child except as provided by this section, the parents, guardian, custodian, or other person with whom the child may be and such other persons as appear to the court to be proper or necessary parties to the proceedings, requiring them to appear before the court at the time fixed to answer the allegations of the complaint. A child alleged to be abused, neglected or dependent shall not be summoned unless the court so directs. A

summons issued for a child who is under fourteen years of age and who is alleged to be a delinquent or unruly child or a juvenile traffic offender shall be served on his parents, guardian, or custodian in his behalf.

If the person who has physical custody of the child, or with whom the child resides, is other than the parent or guardian, then the parents and guardian shall also be summoned. A copy of the complaint shall accompany the summons.

* * *

(B) The court may endorse upon the summons an order directing the parents, or guardian of the child, or other person with whom the child may be to appear personally at the hearing and directing the person having the physical custody or control of the child to bring the child to the hearing.

(C) The summons shall contain a statement advising that any party is entitled to counsel in the proceedings and that the court will appoint counsel or designate a county public defender of joint county public defender to provide legal representation if the party is indigent.

(D) If it appears from affidavit filed or from sworn testimony before the court that the conduct, condition, or surroundings of the child are endangering his health or welfare or those of others, or that he may abscond or be removed from the jurisdiction of the court or will not be brought to the court, notwithstanding the service of the summons, the court may endorse upon the summons an order that a law enforcement officer shall serve the summons and shall take the child into immediate custody and bring him forthwith to the court.

* * *

(E) A party, other than the child, may waive service of summons by written stipulation.

(G) Any person whose presence is considered necessary and who is not summoned may be subpoenaed to appear and testify at the hearing. Any one summoned or subpoenaed to appear who fails to do so may be punished, as in other cases in the court of common pleas, for contempt of court. Persons subpoenaed shall be paid the same witness fees as are allowed in the court of common pleas.

Ohio Revised Code, Sec. 2151.281, Guardian ad litem.

* * *

(B) . . . The court shall appoint a guardian ad litem to protect the interest of a child in any proceeding concerning an alleged abused or neglected child, and in any proceeding held pursuant to section 2151.414 (2151.41.4) of the Revised Code.

In any proceeding concerning an alleged or adjudicated delinquent, unruly, abused, neglected, or dependent child where the parent appears to be mentally incompetent or is under eighteen years of age, the court shall appoint a guardian ad litem to protect the interest of such parent.

The court shall require such guardian ad litem to faithfully discharge his duties, and upon his failure to do so shall discharge him and appoint another. The court may fix compensation for the service or the guardian ad litem which shall be paid from the treasury of the county.

A parent who is eighteen years of age or older and not mentally incompetent shall be deemed sui juris for the purpose of any proceeding relative to his child alleged or adjudicated to be an abused, neglected, or dependent child.

In any case wherein a parent of a child alleged or adjudicated to be an abused, neglected, or dependent

child is under eighteen years of age, the parents of said parent shall be summoned to appear at any hearing respecting the alleged or adjudicated to be an abused, neglected, or dependent child.

Ohio Revised Code, Sec. 2151.33,
Temporary care; emergency medical treatment; reimbursement.

Pending hearing of a complaint filed under section 2151.37 of the Revised Code and service of citations, the juvenile court may make such temporary disposition of any child as it deems best. Upon the certificate of one or more reputable practicing physicians, the court may summarily provide for emergency medical and surgical treatment which appears to be immediately necessary for any child concerning whom a complaint or an application for care has been filed, pending the service of a citation upon its parents, guardian, or custodian. The court may order the parents, guardian, or custodian, if found able to do so, to reimburse the court for the expense involved in providing such emergency medical and surgical treatment, and any such person who disobeys such order may be adjudged in contempt of court and punished accordingly.

When such emergency medical and surgical treatment is furnished a child who is found at the hearing to be a nonresident of the county, and if the expense of such medical and surgical treatment cannot be recovered from the parents, legal guardian, or custodian of such child, the board of county commissioners of the county of which such child has a legal settlement shall reimburse the court for the reasonable cost of such emergency medical or surgical treatment out of its general fund.

CODIFIED ORDINANCES OF THE CITY OF AKRON, OHIO

Section 1870.05, Notice and Consent.

(A) No physician shall perform or induce an abortion upon an unmarried pregnant woman under the age of 18 years without first having given at least twenty-four (24) hours actual notice to one of the parents or the legal guardian of the minor pregnant woman as to the intention to perform such abortion, or if such parent or guardian cannot be reached after a reasonable effort to find him or her, without first having given at least seventy-two (72) hours constructive notice to one of the parents or the legal guardian of the minor pregnant woman by certified mail to the last known address of one of the parents or guardian, computed from the time of mailing, unless the abortion is ordered by a court having jurisdiction over such minor pregnant woman.

(B) No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen (15) years without first having obtained the informed written consent of the minor pregnant woman in accordance with Section 1870.06 of this Chapter, and

(1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or

(2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

Section 1870.06, Informed Consent.

(A) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, and one of her parents

or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, given freely and without coercion.

(B) In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows:

(1) That according to the best judgment of her attending physician she is pregnant.

(2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and physical examination and appropriate laboratory tests.

(3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

(4) That her unborn child may be viable, and capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal

obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

(5) That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

(6) That numerous public and private agencies and services are available to provide her with birth control information, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(C) At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with this Chapter, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information

which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

MOTION FILED
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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1981

CITY OF AKRON

vs.

AKRON CENTER FOR REPRODUCTIVE HEALTH

AKRON CENTER FOR REPRODUCTIVE HEALTH

vs.

CITY OF AKRON

PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

ALAN ERNEST
P.O. Box 2471
Washington, D.C. 20013
(703)437-1178

Counsel for Movant

CONTENTS

Interest of Counsel 1

Summary of Argument 1

Argument

ROE v WADE IS NO LAW AT ALL SINCE THE COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT 3

THE VICTIMS BEING KILLED BY ROE v WADE ARE CONSTITUTIONALLY ENTITLED TO BE ESPECIALLY REPRESENTED BY RETAINED COUNSEL TO DEFEND THEIR RIGHT TO LIFE..14

AUTHORITIES

Cases:

Clarke v. State, 117 Ala. 1 7,10

Commonwealth v. Harmon, 4 Barr. 269 10

Douglas v. California, 372 U.S. 353(1963).....14

Gagnon v. Scarpelli, 411 U.S. 778(1973).....14

Goldberg v. Kelly, 397 U.S. 254(1970).....14

Hamilton v. United States, 26 App. D.C. 382 7

In Re Gault, 387 U.S. 1 (1967).....14

Morrisey v Brewer, 408 U.S. 471(1972).....14

People v. Chavez, 77 Cal. App. 2d 621.....10

Regina v. Trilloe, 174 Eng. Rep. 674 5

Regina v. West, 2 C & K 784 5,6

Rex v. Senior, 1 Moody CC 346 5

Ross v. Oregon, 227 U.S. 150 10

State v. Winthrop, 43 Iowa 519 7

United States v. Altstoetter(The Justice Case), 3 Trials of War Criminals Before the Nuernberg Military Tribunals (1951).....12,14

Viteck v. Jones, 63 L Ed 2d 552 14

Texts:

Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence(7th ed 1860)... 6

4 Blackstone's Commentaries 5

3 Coke's Institutes 5

1 Hawkins, Ch.13, §16.....5

Holmes, The Common Law (Belknap paperback 1963)..11

Lincoln, The Collected Works of Abraham Lincoln (Basler ed. 1952) 10

Russell, A Treatise on Crimes and Misdemeanors (4th ed. 1865)..... 6

Taylor, Manual of Medical Jurisprudence (Penrose Am. Ed. 6th ed. 1866) 6-7

Wharton, A Treatise on the Law of Homicide in the United States (1855) 7

Wharton, Criminal Law and Procedure (12th ed. 1957) 11

U.S. Constitution:

The Fourteenth Amendment "Any Person" 8-9

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

The Court is moved to allow Alan Ernest to represent the victims being killed by Roe v Wade, 410 U.S. 113, as counsel or guardian ad litem.

Interest of Counsel

Alan Ernest is a lawyer in the District of Columbia and a member of the bar of this Court. His interest is to defend the constitutional right to life of the children unborn and born alive being killed pursuant to Roe v. Wade. The parties have not done this.

This is effectively a motion to allow retained counsel to represent the victims being killed, since there will be no expense to this Court, or to the taxpayers.

Summary of Argument

In Roe v Wade, the Court asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment. Thus, Roe v Wade is no law at all, and should be expressly overruled.

This will dispose of all the issues raised by the parties.

The victims being killed are entitled by the U.S. Constitution to be especially represented by retained(no cost to taxpayers) counsel who has authority to cross-examine the evidence in Roe v Wade, which the Court used to condemn the victims to death, and to present evidence on their behalf to establish their right to life under the U.S. Constitution.

It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges Hitler-like assert to legalize mass murder, and then maintain the killings by willfully refusing to allow retained counsel to represent the victims being killed and defend their right to life protected by the Constitution.

The amicus curiae brief by the Legal Defense Fund For Unborn Children filed herein is incorporated by reference.

ARGUMENT

ROE v WADE IS NO LAW AT ALL, SINCE THE COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT

Counsel presents new evidence herein,[1/] not presented by the parties, to show that many of the killings that the Supreme Court asser-

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1./ The new evidence was published in The Washington Post on September 12, 1979, under the caption "WASHINGTON LAWYER CHARGES U.S. SUPREME COURT WITH MASS MURDER," as set out below. That the charging evidence can be published in the dominant newspaper in the nation's capital, but, as the victims are being killed, the evidence can not even be heard in this Court, proves the complete criminal degeneracy of the judicial system. The newly discovered evidence shows the Court asserted to legalize killings defined as murder since before the adoption of the 14th Amendment.

SUMMARY OF ARGUMENT

MANY ROE v WADE KILLINGS ARE MURDER

The evidence shows that many of the killings permitted by Roe v Wade, 410 US 113(1973) were murder in 1868. Since the killings were murder in 1868, then absent a constitutional amendment, the killings are still murder, and Roe v Wade is not law at all.

ARGUMENT

1. Introduction to Evidence

The evidence presented herein shows that, at the time the Fourteenth Amendment was adopted in 1868, the unlawful killing, with malice aforethought, of a child born alive was murder. Killings of children born alive were not treated as a special category, as was abortion.

It is thus absolutely indispensable to examine what "born alive" meant in 1868. It is obvious that, if the life of a child born alive was protected by

ted to legalize in Roe v Wade, 410 US 113, had thereto been defined as murder. It is just as if the Court asserted a right to kill Jews. Obviously, absent a constitutional amendment, these killings are still murder. Justices who have presumed to permit these killings may now be facing the death penalty in very many states.

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the murder laws in 1868, then it is a person within the language and meaning of the Fourteenth Amendment.

The evidence shows that in 1868, born alive did not mean natural birth after nine full months of gestation; nor did it mean birth after viability, "that is, potentially able to live outside the mother's womb, albeit with artificial aid." Roe v Wade, 410 US at 160. If abortion resulted in a live but unviable child that died as a consequence of its not being able to survive outside the womb, it was murder and punishable by the death penalty.

The evidence shows that the hysterotomy is a common method of performing abortions under Roe v Wade. This is essentially a Caesarean in which a live but unviable child is removed from the womb and left to die. The legal authorities show that in 1868, such a killing was murder, and punishable by the death sentence.

In summary, what was murder in 1868, can not now be decreed a constitutional right. Without an amendment to the Constitution, the killings must still be murder, and the Justices who permitted these killings may be guilty of mass murder in the first degree. This is still punishable by the death sentence in many states.

Many people would no doubt be astonished to learn that the case presented herein for the unborn is the very case they would have to present for themselves if their right to life were challenged. For example, take almost any group of persons, such as the insane, invalids, Jews or Catholics. Suppose it were claimed in federal court that the

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2. The English Law

The English law, as reflected in the writings of Coke(3 Inst. 50), Hawkins(1 Hawkins Ch. 13, s. 16) and Blackstone(4 Bl. Com. 198) defined the felonious killing of a child "born alive" as murder, even if the child received the fatal wound in the womb.

These authorities were followed by the English courts in permitting prosecutions of the killings of children born alive as murder. Rex v Senior, 1 Moody CC 346 (1832); Reg. v Trilloe, 174 Eng. Rep. 674 (1842); Reg. v West, 2 C & K 784 (1848).

Most critically, in the English law, a child did not have to be viable to be born alive. In 1848, the leading case of Regina v West, 2 C & K 784, was decided. The indictment for murder alleged that the defendant had inserted a "certain pin" "upward into the womb " of a pregnant woman for the purpose of producing the abortion of a "quick" child; and that this resulted in the child being "prematurely born and brought forth alive from and out of the womb." Id., 784-85. The child died shortly thereafter. A "medical witness" had testified that:

"(I)t was a healthy child; but that, being born at that period of gestation, it was impossible that it could live any considerable length of time separated from the womb of the mother. It was incapable

right of "privacy" announced in Roe v Wade includes the right to kill members of these groups, as well as the unborn. If the burden were suddenly thrust on these groups, as it was thrust on the unborn, to prove that they are persons whose lives are protected by the Fourteenth Amendment, what factual, non-argumentative evidence could they find to estab-

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of maintaining a separate and independent existence." Id., at 786.

The judge, relying on Coke and Blackstone, instructed the jury:

"The prisoner is charged with murder; and the means stated are, that the prisoner caused the premature delivery of the witness, Hensen, by using some instrument for the purpose of procuring abortion; and that the child so prematurely born was, in consequence of its premature birth, so weak that it died. .... I am of opinion(and I direct you in point of law), that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies in consequence of its exposure to the external world, the person who by her misconduct so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder." Id., at 788.

The case of Regina v West, supra, was presented by the leading English writers as the correct statement of the law of murder. See, e.g., 1 J.F. Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence 783 (Waterman Am. ed. 7th ed. 1860); 1 W.O. Russell, A Treatise on Crimes and Misdemeanors 671-672 (4th ed. 1865); A.S. Taylor, A

lish their right to life?

As the case of the unborn shows, it would do no good to object that no one ever heard of such a constitutional right to kill, or to object that such killings had thereto been defined as criminal. And the Fourteenth Amendment merely states that it pro-

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Manual of Medical Jurisprudence 516(Penrose Am. ed. 6th ed. 1866). Consequently, the abortion of a quick but unviable child that resulted in the child being born alive so prematurely that its death was caused by its inability to survive outside the womb, was murder.

3. The American Law Of Murder in 1868.

The English common law of murder of children born alive is significant since American courts used the English common law to construe their murder statutes. Clarke v State, 117 Ala. 1(1898); Hamilton v United States, 26 App. D.C. 382(1905).

American courts cited Coke, Hawkins, Blackstone, and the English court decisions, as authoritative definitions on the law of homicide of children born alive. See, e.g., Clarke v. State, 117 Ala. 1(1898); State v Winthrop, 43 Iowa 519(1876). By 1868, leading American legal authorities had specifically cited Regina v West, supra, as the correct law of murder of a child born alive. (As already noted, that case held that if a criminal abortion resulted in the premature delivery of a quick but unviable child that died after delivery as a consequence of its being so prematurely delivered that it could not survive outside the womb, it was murder.) See, e.g., F. Wharton, A Treatise on the Law of Homicide in the United States 96-97(1855). By 1868, this appears to be the uncontradicted view.

tects life of "any person." So, as with the unborn, the Amendment does not expressly refer to the insane, or invalids, or Jews, or Catholics; and its legislative history does not appear to specifically refer to any of these groups. As with the unborn, the murder laws do not expressly refer to the insane,

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Consequently, the evidence shows that the life of a quick but unviable child born alive was protected by the murder laws in 1868.

4. The Law Of Murder In 1868 And The Fourteenth Amendment

Since the evidence shows that the life of a quick but unviable child was protected by the murder laws in 1868, the evidence likewise establishes that the child so born alive is a person within the language and meaning of the Fourteenth Amendment.

By seizing upon viability, Roe v Wade permits the killings of quick but unviable children born alive. The Supreme Court presumed to decree the killings of these children to be a constitutional right without any examination whatever to see if these children were persons within the language and meaning of the Fourteenth Amendment. It is a naked decree without any investigation into the law of murder of children born alive.

This raises the question,- Does the Supreme Court have the Hitler-like power to decree murder to be a constitutional right? If invalids were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill invalids? If Jews were protected by the murder laws in 1868, can the Supreme Court decree, without evidence or investigation, a constitutional

or invalids, or Jews, or Catholics; and their legislative histories, to the extent they have any, do not appear to specifically refer to any of these groups. The principle in the Declaration of Independence, that all people are "created" equal and endowed with an unalienable right to "life," having been

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right to kill Jews? If newspaper editors were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill newspaper editors?

No doubt the Supreme Court bears the burden of proving, by evidence so conclusive that it will not admit of a rational doubt, that it possesses the power to decree murder to be a constitutional right.

5. The Hysterotomy Abortion Under Roe v Wade

A common way to perform abortions under Roe v Wade is by hysterotomy. See, Commonwealth v. Edelin, 359 NE 2d 4(Mass. 1976). A hysterotomy is essentially a Caesarean, in which a live but unviable child is removed from the womb and left to die. 1 Hearings Before the Subcommittee On Civil And Constitutional Rights Of the Committee of the Judiciary, House of Representatives On Proposed Constitutional Amendments on Abortion 397 (94th Cong., 2nd Sess. 1976).

As established by medical testimony during the 1976 House Abortion Hearings, "With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry .... Almost all were born alive." Id., at 397.

Consequently, by definition, in 1868, these hysterotomy abortions could have been prosecuted as murder.

sneered out of court in the unborn's case, now provides no assurance for anyone. So what factual, non-argumentative evidence is there for members of these groups to protect themselves from extermination?

The case presented herein for the unborn,

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6. Roe v Wade and Mistake of Law

The Supreme Court itself has recognized that constitutional provisions against ex post facto laws do not apply to judicial decisions that are a mistake of law. Ross v Oregon, 227 US 150(1913). Consequently, if Roe v Wade is a mistake of law, then mass murder is being perpetrated in America. The Roe v Wade hysterotomy killings, by definition under the common law, and thus constitutional law, violate the positive criminal murder statutes throughout the United States.

The killings of children born alive have been prosecuted as murder in the first degree, Comm. v Harmon, 4 Barr. 269 (Pa. 1846)(child thrown in creek); or murder in the second degree, Clarke v State, 117 Ala. 1 (1898)(wife beaten, child die from injuries); or manslaughter, People v Chavez, 77 Cal. App. 2d 621(1947)(child neglected),- according to the facts of the particular case, as in any other homicide.

In connection with these judicial killings, it is relevant to note that the Supreme Court decreed murder to be a constitutional right without any examination whatever of the law of murder of children born alive. And as Abraham Lincoln noted, "(I)t is an established maxim in morals that he who makes an assertion without knowing whether it is true or false, is guilty of falsehood; and the accidental truth of the assertion, does not justify or excuse him." 1 The Collected Works of Abraham Lincoln 384 (Basler ed. 1953). Since Lincoln's day, this "maxim in morals"

supra note 1, is thus the case for everyone else. The common law is the dictionary; it has traditionally been used to define the terms of the homicide statutes. It is this same body of factual evidence upon which all groups must ultimately rely to establish

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has also been a textbook definition of perjury. See, 3 Wharton's Criminal Law and Procedure, § 1308, p. 673 (12th ed. 1957).

Consequently, rational people are entitled to believe, and a jury may be permitted to find, that the process by which the Supreme Court decreed murder to be a constitutional right is perjury or criminal fraud. It seems reasonable that such judicial killings, after such prolonged deliberation and adherence, could be prosecuted as murder in the first degree. Many states still punish mass murder in the first degree with the death sentence.

It may be that the judges responsible for the judicial killings did not believe that they were breaking the law. But, as Justice Oliver Wendell Holmes once wrote, "Ignorance of the law is no excuse for breaking it." "It is no doubt true that there are many cases in which the criminal could not have known that he was breaking the law, but ... the lawmaker has determined to make men know and obey." Holmes, The Common Law 41 (Howe ed. paperback 1963).

It now full well appears that the Justices of the Supreme Court of the United States have presumed to decree murder to be a constitutional right, without any evidence or examination whatsoever, with the death penalty the possible consequence of their decision being a mistake of law.

It now appears that, unless the Supreme Court can prove by evidence, beyond a doubt based on reason, that it has the Hitler-like power to decree mass

their right to life. The evidence, supra n.1, conclusively proves that the Supreme Court has Hitler-like, that is, by naked decree without any investigation of the law of murder, asserted to legalize mass murder. Roe v Wade is a mistake of law, that is, no law at all. All the countless thousands of

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murder to be a constitutional right, then Roe v Wade is just such a mistake of law.

CONCLUSION

Is government of laws founded upon evidence, or the mere naked decrees of men holding office for life?

The evidence proffered herein would appear sufficient to permit reasonable people to conclude beyond a reasonable doubt that the Supreme Court of the United States has committed mass murder in the first degree. The evidence would appear sufficient for reasonable people to conclude that, upon a scale never seen before in the peacetime history of the world, "The dagger of the assassin was concealed beneath the robe of the jurist." The Justice Case, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 985 (GPO 1951).

If the United States were being ruled over by a Tribunal of Murderers, holding office for life, nakedly decreeing mass murder to be a constitutional right, in open defiance of the evidence, and presuming to be blindly obeyed by all courts, executives, legislatures, and people whatever without question, regardless of the evidence, then surely it would be the most astounding event in the legal history of the human race.

born alive Roe v Wade killings since 1973 can be prosecuted as murder. Anyone who takes part in this national scheme of on-going killings in any intentional manner whatever, even by mere words of encouragement in Court, can be prosecuted for complicity in mass murder just as if Roe v Wade had never been decided. The Supreme Court is not above the law of murder. Roe v Wade is no law at all, and ought to be expressly overruled to reflect the true state of the law.

The evidence shows that the United States is being ruled over by a tribunal of murderers which has Hitler-like asserted to legalize mass murder, and maintains the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend the victims right to life under the U.S. Constitution. But even the Supreme Court is not above the law of murder, and many states still punish mass murder with the death penalty.

THE VICTIMS BEING KILLED BY ROE v WADE ARE CONSTITUTIONALLY ENTITLED TO BE ESPECIALLY REPRESENTED BY RETAINED COUNSEL TO DEFEND THEIR RIGHT TO LIFE UNDER THE CONSTITUTION.

The victims being killed have a constitutional right to be especially represented by retained(no cost to taxpayers) counsel to defend their right to life under the U.S. Constitution. 2/

Alan Ernest
Counsel

2./ Goldberg v Kelly, 397 U.S. 254, 268-270(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778(1973); Viteck v Jones, 63 L Ed 2d 552(1980); Gideon v Wainwright, 372 U.S. 335 (1963); United States v Altstoetter(The Justice Case), 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1046 (1951).

The right to retained counsel under these circumstances is certain and indisputable. It can not be pretended that it is any longer the government of the United States, or any government of Constitution and laws, wherein judges assert to legalize mass murder, and then maintain the killings year after year by willfully refusing to allow counsel to represent the victims being killed and defend their right to life under the Constitution.

The amicus curiae brief filed herein by the Legal Defense Fund For Unborn Children is incorporated by reference in its entirety.

A I

The photograph, supra A-1, shows a second stage abortion by prostaglandin. Such abortions not uncommonly result in the child being born alive.[1/] This Court could be prosecuted for murder for such a killing. There have been many thousands of such killings under Roe v Wade. And witnesses live to tell.

And if the child were killed in the womb and born dead, then this Court could be prosecuted for criminal extermination in violation of the Fifth and Fourteenth Amendments and 18 U.S.C. 242.[2/]

As the Court studies the face of this victim of Roe v Wade, let it contemplate that a government of laws shall be restored, and the law shall call the killers to account.

1./ Floyd v Anders, 440 F. Supp. 535,538(1977). The common second stage abortion techniques-hysterotomy, prostaglandin, and even salt poisoning-can result in the child being born alive. Jefferies & Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981.

2./ The amicus curiae brief by the Legal Defense Fund For Unborn Children shows that the unborn are persons whose lives are protected by the Fifth and Fourteenth Amendments of the U.S. Constitution.Thus their lives are also protected by 18 U.S.C. 242.

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Nos. 81-746 and 81-1172

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AND

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Cross-Petitioners

v.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR PETITIONER CITY OF AKRON

ROBERT D. PRITT
Director of Law
City of Akron
166 South High Street
Akron, Ohio 44308-1655
(216) 375-2031
Attorney for Petitioner

Of Counsel:
KAREN L. EDWARDS-SMITH
9821 Olde Eight Road
Northfield, Ohio 44067
(216) 467-8571

Washington, D.C. • THIEL PRESS • (202) 638-4521

TABLE OF CONTENTS

	Page
Table of Authorities	ii
Statment of the Case	1
Argument	
I. THE DECISION OF THIS COURT GARY- NORTHWEST INDIANA WOMEN'S SERVICES v. BOWEN, 496 F. Supp. 894 (N.D. Ind. 1980); aff'd sub. nom., GARY-NORTHWEST INDIANA WOMEN'S SERVICES, INC. v. ORR, 451 U.S. 934 (1981), SHOULD BE AFFIRMED	9
II. SECTION 1870.03 OF THE AKRON ORDINANCE, WHICH REQUIRES THAT ABORTIONS SUBSEQUENT TO THE FIRST TRIMESTER OF PREGNANCY BE PERFORMED IN HOSPITALS IS REASONABLY RELATED TO THE STATE'S COMPELLING INTEREST IN PRESERVING AND PROTECTING MATERIAL HEALTH.	15
Conclusion	20

TABLE OF AUTHORITIES

CASES	Page
Akron Center for Reproductive Health, et al. for certiorari, No. 81-1172 at 25-26	13
Birth Control Centers, Inc. v. Reizen, 508 F. Supp. 1366 (E.D. Mich. 1981)	7
Doe v. Bolton, 410 U.S. 179 (1973)	17
Eisenstadt v. Baird, 405 U.S. 438, 470 (1972)	18, 19
Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F. 2d 1141 (7th Cir. 1974)	6, 7
Gary-Northwest Indiana Women's Services, Inc. v. Bowen, 496 F. Supp. 894 (N.D. Ind. 1980), aff'd sub. nom. Gary Northwest Indiana Women's Services, Inc. v. Orr, 451 U.S. 934 (1981)	5, 9, 10, 11, 12, 13, 14, 15, 16
Hallmark Clinic v. North Carolina Department of Human Resources, 519 F. 2d 1315 (4th Cir. 1975) aff'g 380 F. Supp. 1153, 1158 (E.D.N.C. 1974)	6
H.L. v. Matheson, 450 U.S. 398, at 413 (1981)	19
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)	8
Roe v. Wade, 410 U.S. 113 (1973)	1, 5, 9, 10, 11, 15,16, 17, 18

TABLE OF AUTHORITIES (CONTINUED)

	Page
Westchester Women's Health Org., Inc. v. Whalen, 475 F. Supp. 734 (S.D.N.Y. 1979)	7
Women's Medical Center of Providence v. Cannon, 463 F. Supp. 531 (D.R.I. 1978)	7
Word v. Poelker, 495 F. 2d 1349 (8th Cir. 1974)	7

STATEMENT OF THE CASE

On February 28, 1978, the Akron City Council enacted Ordinance No. 160-1978, comprehensively regulating the performance of abortions to protect the health and safety of women seeking such services. Included in this legislation was a requirement that all abortions performed during the second trimester of pregnancy be done in a hospital. Section 1870.03 reads: "No person shall perform or induce an abortion upon a pregnant woman subsequent to the end of the first trimester of her pregnancy unless such abortion is performed in a hospital." This requirement is rationally based upon the City's desire to protect the maternal health and well-being of women, and prior to this litigation such a requirement was believed to be unquestionably constitutional. Roe v. Wade, 410 U.S. 113 (1973).

Testimony given at trial by physician-witnesses, including one who performs abortions at Plaintiff clinic, amply shows that abortions after the first twelve weeks of pregnancy should be performed in a hospital. Dr. B., a physician performing abortions at Plaintiff Womencare, Inc., testified that an abortion on a woman who is more than twelve weeks along should be done in a hospital because it is safer. Tr. VII, 131. According to Dr. C., a physician with Plaintiff Akron Women's Clinic, the clinics are only

equipped to deal with minor complications. Tr. VII, 20.

Dr. Schmidt, a past president of the American College of Obstetrics and Gynecology, testified that a second trimester abortion should be performed in a hospital and that this was a standard recommendation contained in official statements of the College. Tr. X, 29.

It is argued on behalf of the abortion clinics that Section 1870.03 has the effect of inhibiting second trimester abortions, as Akron hospitals are not available to meet the need for second trimester abortions, thus making abortions less geographically accessible. They base this argument on testimony by Dr. Tietze that approximately five hundred to seven hundred second trimester abortions would be requested in a community the size of Akron based on the national experience (Tr. IV, 152) and that only nine second trimester abortions were performed in Akron during the year from May of 1977 to April of 1978.

This argument fails for several reasons. First, Dr. Tietze's testimony was based upon the national percentage of second trimester abortions. Whether such data is applicable to Akron or reflects the actual number of second trimester abortions requested by Akron residents is doubtful. Secondly,

the national average, according to Dr. Tietze, has declined over the past five years by fifty percent, indicating that the need for second trimester abortions will continue to decline. Tr. IV, 150. Thirdly, as found by the Sixth Circuit Court of Appeals, there are two Akron hospitals which perform second trimester abortions. Pet. App. 19a. There was no evidence presented at trial that abortions were denied to any woman by these two Akron hospitals or their doctors, nor was there any evidence that these hospitals would not permit the D & E procedures, neither was there any evidence to show that second trimester abortions could not be obtained in hospitals in the nearby cities. To the contrary, the Sixth Circuit Court of Appeals found that women were referred to clinics in nearby Cleveland. Pet. App. 19a.

Clearly, second trimester abortions are available in and close to the Akron area.[1] The clinics in this case advertise over a wide area of Northeastern Ohio (Tr. VI, p. 101) including Canton, Youngstown and Warren newspapers. Patients are

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[1]This Court may take judicial notice that the City of Akron is physically located in the populous Northeast Ohio area. The cities of Cleveland, Canton, and Youngstown/Warren are but a short drive to Akron from the north, south, and east respectively.

referred to Akron Center's Clinic from as far away as Mansfield and Columbus. Tr. VI, 103-104. Further, there is no evidence on the record that second trimester abortions are not available and being performed at area hospitals or other facilities in the Akron area, but outside the city limits of Akron itself.

Although the clinics make much of the purported safety and the community's "need" for mid-trimester D & E abortions, neither their safety nor anyone's "need" to have these clinics perform them is clearly established on this record. At the time of trial, defense expert Dr. Schmidt, past president of the American College of Obstetricians and Gynecologists (A.C.O.G.) and former chairman of its Professional Standards Committee, testified that second (mid-) trimester abortions should be performed in hospitals. Tr. X, 29.

He did not believe, as these clinics seem to argue, that the safety of such procedures is clearly established for all clinics because a recognized source of medical data may have reported a good safety record. Tr. X, 47. When pressed, he stated flatly that, as of the time of trial:

> I can assure you that there is no change in the attitude of the College [A.C.O.G.] toward that recommendation, that mid-trimester abortions should be done in a hospital. Tr. X, 47.

In an attempt to get around this evidence, the clinics attempt to show that the D & E procedure is so "safe" that this Court should abandon the Roe v. Wade "trimester" approach and adopt the theory rejected by both this Court and the District Court in Gary-Northwest Indiana Women's Services v. Bowen, 496 F. Supp. 894 (N.D. Ind. 1980), aff'd sub. nom. Gary Northwest Indiana Women's Services, Inc. v. Orr, 451 U.S. 934 (1981). Examination of these purported safety "facts" demonstrates, however, that none of them are sufficiently convincing to form the basis of a new constitutional rule which should supplant that of Roe. Equally telling is that all of the evidence supporting the alleged "safety" of nonhospital D & E abortions adduced in this case rests on assumptions concerning the availability of ancillary medical support services and the quality of in-hospital abortions. Those assumptions, however, find no support on this record.

As the record and appendices in this case make clear, it is not the particular abortion technique which makes a given abortion "safe," but the entire range of services and safety procedures in place and offered at a given clinic. The clinics' own supplemental brief in support of their cross-petition for certiorari contains the 1982 A.C.O.G. guidelines for "ambulatory care facilities providing abortion

services." (App. B to Supplemental Brief of Cross-Petitioners at 3a). Those standards do not even mention D & E abortions. Neither do they purport to opine on their alleged "safety." Instead, they approach the entire question of abortion safety (including that of those performed in the first trimester) from a perspective which focuses on the preservation of maternal health. The 1982 A.C.O.G. guidelines provide:

> That clinics should have written transfer agreements with nearby hospitals for the transfer of patients needing emergency treatment. (Cross-petition, Supplemental Brief at 3a.) (emphasis added).

In the case at bar, the only evidence in the record concerning the treatment of an emergency case is one involving a minor who was sent to the hospital emergency room — in her sister's car — because the physician felt someone should see her. Tr. VI, 134. Although this ordinance does not require that a clinic have a written transfer agreement, such statutes have been held to be unconstitutional. Hallmark Clinic v. North Carolina Department of Human Resources, 519 F. 2d 1315 (4th Cir. 1975) aff'g 380 F. Supp. 1153, 1158 (E.D.N.C. 1974) (requirement termed as a "thinly disguised effort to evade Roe and Doe"); Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F. 2d 1141 (7th

Cir. 1974); Word v. Poelker, 495 F. 2d 1349 (8th Cir. 1974); Birth Control Centers, Inc. v. Reizen, 508 F. Supp. 1366 (E.D. Mich. 1981); Women's Medical Center of Providence v. Cannon, 463 F. Supp. 531 (D.R.I. 1978). But c.f., Westchester Women's Health Org., Inc. v. Whalen, 475 F. Supp. 734 (S.D.N.Y. 1979). The A.C.O.G. further provides that:

> A clinic should provide 'specialized' counselling which 'explores the options for the management of an unwanted pregnancy, examines the risks, and allows sufficient time for reflection prior to making an informed decision. (Cross-petition, supplemental brief at 4a) (emphasis added)

In the case at bar, Section 1870.06(B), provides for "specialized" counselling regarding physiology, risks, and options. Section 1870.07 provides for a 24-hour waiting period between counselling/consent and the actual abortion. Both were struck down. For these clinics to cite an A.C.O.G. standard which supports the ordinance at bar highlights the narrow view of "safety" they appear to have.

As the record shows, these clinics assume that all women who come to their facilities have decided to have an abortion. Tr. VII, 51-54. They consider the information contained in Section 1870.06(B) regarding risks, options, and anatomical facts to be "irrelevant". Tr. VI, 121-122. The requirement that

the physician personally determine that the consent is informed is "burdensome," and the "specialized" counselling recommended by A.C.O.G. is provided — not by the physician — but by non-college graduates with no specialized training who are supervised by the clinic director, a non-physician. Tr. VII, 9.

The Sixth Circuit held below that a requirement that the physician make sure that the consent is truly informed is a violation of the woman's right to privacy and the "undesired and uncomfortable straightjacket" to which this Court referred in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) but the A.C.O.G. recommends that the "physician performing the abortion should verify that the [suggested] counselling has taken place" (Supplemental Brief of Cross-Petitioners at 4a). Even more importantly, the record demonstrates that: 1) the physicians at these clinics do not spend enough time with each patient to verify the extent and quality of the counselling; 2) they are paid on a per/patient basis (i.e. they do not get paid for the time spent unless the abortion is performed) (Tr. VI, 97); and 3) they do not supervise the counsellors or control the content of counselling practice. Tr. VII, 9. The patients do not even know the physician's name when they come to the clinic.

In short, these clinics do not even meet the standards that they themselves cite as support for

their claim that mid-trimester D & E abortions may "safely" be performed at their facilities.

It is further important to note that while the clinics cite the 1982 A.C.O.G. manual of standards as supporting the performance of early second trimester abortions in such clinics, A.C.O.G.'s endorsement is not as sweeping as the evidence at trial which is relied upon by the clinics as favoring discarding the second trimester standard enunciated in Roe. The A.C.O.G. manual states:

> Generally, abortions in the physician's office or out-patient clinic should be limited to 14 weeks from the first day of the last menstrual period. In a hospital-based or in a free-standing ambulatory surgical facility, or in an out-patient clinic meeting the criteria required for a free-standing surgical facility, abortions should be limited to 18 weeks from the last menstrual period. (Cross-Petitioner's Brief, App. B, p. 16). (emphasis added.)

Thus, out-patient clinics which do not meet the criteria for a free-standing surgical facility are still limited to first trimester abortions under the A.C.O.G. regulations. (The first trimester of pregnancy is measured either as the first 12 weeks from conception or the first fourteen weeks from the first day of the last menstrual period.)

ARGUMENT

I. THE DECISION OF THIS COURT IN GARY-

NORTHWEST INDIANA WOMEN'S SERVICES V. BOWEN, 496 F. Supp. 894 (N.D. Ind. 1980); aff'd sub. nom., GARY-NORTHWEST INDIANA WOMEN'S SERVICES, INC. V. ORR, 451 U.S. 931 (1981), SHOULD BE REAFFIRMED.

Simultaneously with the enunciation in Roe that a woman's right of privacy encompasses the freedom to choose in consultation with her physician to terminate her pregnancy, this Court held that the state "may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health" at approximately the end of the first trimester. (Emphasis added.) Roe, supra, 410 U.S. at 163-164. In so holding, this Court rejected the idea that a woman has an absolute right to an abortion without any state interference. It was specifically recognized that, from and after the first trimester of pregnancy, the states had regulatory power to protect the health of women seeking abortions.

In addressing the state's interest in the health of the mother, this Court stated:

> With respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact, . . . that until the end of the first trimester mortality in abortion may be less than

> mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like. (Emphasis added.) Roe, supra, 410 U.S. at 163-164.

In challenging Section 1870.03 of the Akron ordinance, the clinics are seeking a reversal of this Court's decision in Roe. While this Court has redefined the standard applicable to first trimester abortions, no such modifications have been made regarding permissible state regulation of second trimester abortions. In holding Section 1870.03 constitutional, the Sixth Circuit Court of Appeals recognized that in Gary-Northwest "the Supreme Court has now had an opportunity to retreat from the 'bright line' drawn in Roe v. Wade and has declined to do so." This Court should continue to maintain that 'bright line.'

As recognized by the Court of Appeals, the arguments made by the plaintiffs in Gary-Northwest

were nearly identical to those made in the present case. Pet. App., 22a. Although the Indiana statute involved in Gary-Northwest provided for the performance of abortions in free-standing ambulatory surgical facilities as well as in hospitals, it was the second trimester dividing line — not the authorized locations — which was at issue in that case. To that extent, Gary-Northwest controls this case. Cross-Petitioners' description of the Gary-Northwest case, therefore, attempts to create a difference where none exists. The issue involved in both Gary-Northwest and the Akron ordinance was the regulation of the place where second trimester abortions may be performed. In Gary-Northwest, the District Court summarized them as follows:

> The plaintiffs' arguments are as follows: (1) Only one Indiana hospital . . . will allow the use of its facilities for the performance of non-therapeutic second trimester abortions; (2) Some indigent women cannot afford the expense of traveling to [this hospital] . . . ; (3) Indiana's requirement that all second trimester abortions be performed in a hospital therefore requires some indigent women to bear a child rather than acquire a non-therapeutic second trimester abortion; (4) Childbirth is more dangerous to a mother's health than a second trimester abortion, if the abortion is performed during approximately the first half of the second trimester pregnancy, and if the dilation and evacuation [D &

E] method is used; (5) Therefore, Indiana's hospitalization requirement forces some indigent women to pursue a course of action which is more dangerous to their health than the course of action which they would pursue in the absence of Indiana's hospitalization requirements; (6) Therefore, Indiana's hospitalization requirement does not 'reasonably relate to maternal health' and is accordingly unconstitutional. (citation omitted)" Gary-Northwest Indiana Women's Services, Inc. v. Bowen, supra, 496 F. Supp. at 899-900.

In the case at bar, the arguments made by Cross-Petitioner differ only in that there is no focus on indigency:

> [C] urrent medical data prove that the performance of second trimester D & E abortions in out-patient facilities is widely accepted in the medical community, and that this practice is as safe as, or safer than, in-hospital procedures. Second trimester D & E abortions are not only twice as safe as the earlier methods, they are much safer than childbirth. (citation omitted) Furthermore, as the Sixth Circuit found, the blanket prohibition imposed by Section 1870.03 causes severe limitations on access, exposing women to far greater health risks than if physicans were allowed to perform the less-costly D & E abortions in clinics. (citation omitted) Cross-Petition of Akron Center for Reproductive Health, et al. for certiorari, No. 81-1172 at 25-26.

Given this identity of issues, the reasons why

this Court should affirm the judgment below on this case are the same as those mentioned by Judge Sharp in Gary-Northwest and later affirmed by this Court:

> To adopt [this] theory and hold [the] hospitalization requirement unconstitutional because of its impact on non-therapeutic early second trimester D & E abortions would ultimately require that the second trimester be split for purposes of determining the constitutionality of regulations. Such a holding would require states to adopt, for their maternal health regulations, some cutoff other than the end of the first trimester.
>
> * * *
>
> Interpreting Roe to require that second trimester regulations except specific types of abortions which may be safer than childbirth would require re-litigation of the regulation's constitutionality with each change in the availability of abortions, with each improvement in abortion technique, and with each publication of statistics showing that abortion skills have improved. Such an interpretation would result in repeated re-litigation of the constitutionality of the same statute. It is the policy of the Supreme Court to avoid, if possible, the creation of rules of law which increase litigation. Roe should not be given an interpretation which results in repeated re-litigation of a statute's constitutionality. Roe does not render the constitutionality of second trimester regulation subject to either the availability of abortions or the improvements in medical

techniques and skills.

> The test for determining the constitutionality of statutes regulating second trimester abortions is not whether the statute has the statistically demonstrable result of decreasing maternal morbidity or mortality for specific groups of abortions . . . The ultimate test is a broader test: whether the legislature acted reasonably in determining that the regulation would promote maternal health . . . A statutory regulation of second trimester abortions is constitutional if it was reasonable for the state to conclude that the regulation would promote maternal health. Gary-Northwest Indiana Women's Services v. Bowen, supra, 496 F. Supp. at 896-97, 899, 901-902. (emphasis added).

The Akron City Council acted reasonably in determining that the regulation would promote maternal health as is shown by an examination of the record in this case.

II. SECTION 1870.03 OF THE AKRON ORDINANCE, WHICH REQUIRES THAT ABORTIONS SUBSEQUENT TO THE FIRST TRIMESTER OF PREGNANCY BE PERFORMED IN HOSPITALS IS REASONABLY RELATED TO THE STATE'S COMPELLING INTEREST IN PRESERVING AND PROTECTING MATERNAL HEALTH.

As specifically set foth in Roe v. Wade, a state

may constitutionally regulate the performance of a second trimester abortion "to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements . . . as to the facility in which the procedure is to be performed . . . " 410 U.S., at 163. In light of this Court's enunciation in Roe, and its affirmance of Gary-Northwest, it is clear that a state's interest in maternal health is reasonably related to a second trimester hospitalization requirement.

While there have been and will continue to be advancements in medical science relating to abortion procedures, this in no way lessens the state's legitimate interests in protecting and preserving the health of women seeking abortions. The medical debate pertaining to the relative safety of various procedures, as is evidenced by the conflicting testimony presented at trial, is just that, a medical debate: The constitutional issue before this Court is at what point in a woman's pregnancy does the state's interest in maternal health become compelling so as to permit the reasonable regulation of abortions. This involves a balance of the woman's right not to be unduly burdened in her choice to terminate her pregnancy, and the state's interest in protecting the

woman's health. The constitutionally permissible dividing line between these interests has been clear since the recognition of the woman's protected right of privacy in Roe. No such medical certainty has or will ever exist, as is shown by this Court's language in Roe, that "the 'compelling' point, in the light of present medical knowledge, is at approximately the end of the first trimester." (Emphasis added.) Roe, supra, 410 U.S. at 163. The dividing line for purposes of regulating the abortion procedure is drawn from and after the first trimester of pregnancy. This 'bright line' should not now be reversed as the state still has a compelling interest in maternal health.

It should seem obvious that after Doe v. Bolton, 410 U.S. 179 (1973), the term "safety," like the term "health," encompasses many factors. Among these are the qualifications of staff, the facilities available, standard operating procedures, and emergency plans. No court is qualified to rule, as a matter of law, that non-hospitalized D & E procedures are "safe." That decision should depend on the clinic and doctor involved, the "health" of the patient and many other factors unique to each case. Thus, if a non-hospitalized D & E is no more dangerous than a hospitalized one, it is arguable that reasonable minds can differ over the degree to which clinic abortions may be "as dangerous as" or "safer

than" hospitalized abortions. Since it is certainly reasonable for the legislature to conclude that "no more dangerous than" is equivalent to "just as dangerous."[2] The second trimester rule is "reasonably related to maternal health" as required by Roe.

When one considers the impact of the 1982 A.C.O.G. standards and the expert testimony in this record which supports the proposition that the relative "safety" of all abortions depends on the entire range and quality offered in the non-hospital setting, the dangers of judicial tampering with legislatively devised regulatory schemes on the basis of isolated statistics or less-than-unanimous medical opinion should be clear. They were well summarized in the dissenting opinion of Chief Justice Burger in Eisenstadt v. Baird, 405 U.S. 438, 470 (1972):

> The actual hazards of introducing a particular foreign substance into the human body are frequently controverted, and I cannot believe the unanimity of expert opinion is a prerequisite to a State's exercise of its police power, no matter what the subject matter of the

[2]The claim that a clinic D & E is "safer" than those performed in hospitals is extremely short-sighted. Serious complications, especially hemorrhage, occur with four to five times greater regularity after the fourteenth week of pregnancy. (Tr. X, 120) Such complications, especially hemorrhage, should be treated in a hospital. (Tr. X, 119) (Dr. Williams)

> regulation. Even assuming no present dispute among medical authorities, we cannot ignore it has become commonplace for a drug or food additive to be universally regarded as harmless on one day and to be condemned as perilous the next. It is inappropriate for this Court to overrule a legislative classification by relying on the present consensus among leading scientific authorities. The commands of the Constitution cannot fluctuate with the shifting tides of scientific opinion.

Section 1870.03 of the Akron ordinance is reasonably related to the City's compelling interest in maternal health. The fact that some mid-trimester abortions may be done successfully in a minimally equipped clinic does not invalidate the regulation. The state is not required to finetune its statutes to facilitate or encourage abortions. H.L. v. Matheson, 450 U.S. 398, at 413 (1981).

CONCLUSION

For the foregoing reasons, the appropriate disposition of this case is to affirm the Court of Appeals as to Section 1870.03 of the Akron ordinance.

Dated September 24, 1982.

Respectfully submitted,

Robert D. Pritt
Director of Law
The City of Akron
304 Municipal Building
Akron, OH 44308-1655
(216) 375-2031
Attorney for Petitioner

OF COUNSEL:

Karen L. Edwards-Smith
9821 Olde Eight Road
Northfield Ohio 44067
(216) 467-8571

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF OF PETITIONER CITY OF AKRON

Robert D. Pritt
Director of Law
The City of Akron
166 S. High St.
Akron, OH 44308-1655
(216) 375-2031
Attorney for Petitioner
(Counsel of Record)

Of Counsel:
Karen L. Edwards-Smith
9821 Olde Eight Road
Northfield, OH 44067
(216) 467-8571

Alan G. Segedy
40 E. Mill St.
Akron, OH 44308
(216) 253-5535

TABLE OF CONTENTS

	Page
Table of Authorities	ii
Argument	
I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS.	1
II. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE MINOR'S HEALTH BY REQUIRING PARENTAL OR JUDICIAL CONSENT TO AN IMMATURE, UNEMANCIPATED MINOR'S ABORTION.	2
III. THE STATE HAS A LEGITIMATE INTEREST IN INSURING INFORMED CONSENT.	6
Conclusion	10

TABLE OF AUTHORITIES

Cases	Page
Adickes v. S.H. Kress & Co., 398 U.S. 144 (1970)	4
Bellotti v. Baird, 428 U.S. 132 (1976)	1
Bellotti v. Baird, 443 U.S. 622 (1979)	6
California v. Taylor, 353 U.S. 553, (1957)	4, 5
H.L. v. Matheson, 450 U.S. 398 (1981)	1, 2, 6
Maher v. Roe, 432 U.S. 464 (1977)	1, 2, 9
O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980)	4, 5
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)	1
Roe v. Wade, 410 U.S. 113 (1973)	1, 2
United States v. Santana, 427 U.S. 38 (1976)	3, 4

I. THE RULING BELOW CONFLICTS WITH THE DUE PROCESS STANDARD APPLIED BY THIS COURT IN DETERMINING THE CONSTITUTIONALITY OF ABORTION REGULATIONS.

The standard of review applied to legislation regulating the abortion decision, as enunciated by this Court in decisions subsequent to Roe v. Wade, 410 U.S. 113 (1973), is whether the regulation "unduly burdens" a woman's constitutionally protected right to choose whether or not to continue her pregnancy. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 428 U.S. 132 (1976); Maher v. Roe, 432 U.S. 464 (1977); H.L.v. Matheson, 450 U.S. 398 (1981).

Respondent-Cross-Petitioners assert that only a compelling state interest, and a showing that the regulations are narrowly drawn to serve that interest, is sufficient to justify state regulation of the abortion decision. In light of the decisions of this Court permitting first trimester regulation, it is clear that a less stringent standard of review is applied by this Court in evaluating the constitutionality of regulations which do not "unduly burden" the woman's choice.

The two-tier analysis applied by the Court of Appeals subjects abortion regulations to a more

stringent standard of review than that applied by this Court. The first step applied by the appellate court inquired as to whether the regulation had a "legally significant impact or consequence" on the abortion decision. If a legally significant impact was found, the court went on to require a compelling state interest. If a compelling state interest was found, the court then looked to whether the regulation imposed an undue burden. Such a test has never been applied by this Court. Rather, this Court has consistently applied an "unduly burdensome" standard to define the threshold for strict scrutiny. Further, this Court in Matheson, supra, upheld a regulation which required prior parental notice where a minor seeks an abortion. Such regulation clearly had a legally significant impact, but was not unduly burdensome. As noted in Maher, supra, 432 U.S. at 473, "the right in Roe v. Wade, can be understood only by considering both the woman's interest and the nature of the state's interference with it."

II. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING THE MINOR'S HEALTH BY REQUIRING PARENTAL OR JUDICIAL CONSENT TO AN IMMATURE, UNEMANCIPATED MINOR'S ABORTION.

The Court of Appeals for the Sixth Circuit held Section 1870.05(B) unconstitutional as it is "inappro-

priate, on the basis of deference to parental rights, to provide a possible third-party veto over the decision of the pregnant woman and her doctor to terminate the patient's pregnancy." The Akron ordinance does not impose a third-party veto over the abortion decision; rather, the ordinance provides a constitutionally required alternative procedure for a minor to obtain authorization for an abortion.

Certiorari was granted by this Court on the question of "whether a child under the age of fifteen years can be required to obtain the consent of one parent or her legal guardian or a court order authorizing the minor to consent to an abortion." The City did not emphasize this part of the District Court's holding in the Court of Appeals because that issue was fully briefed and argued in that Court by the Defendant-Intervenors. As the constitutionality of Section 1870.05(B) was fully argued in the Court of Appeals, the question is properly before this Court.

The cases cited to support the Respondents-Cross-Petitioners' contention, however, in no way foreclose review by this Court. The case of United States v. Santana, 427 U.S. 38, 41 n. 2 (1976), merely acknowledges the principle that the Supreme Court will not consider an issue which was not raised in the Court below. Section 1870.05(B) was appealed to and decided by the court below.

The position of this Court in the case of Adickes v. S.H. Kress & Co., 398 U.S. 144, 146 n. 2 (1970), is quite similar to the one expressed in Santana, except that this Court noted that "where issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them." (Emphasis added). The Court left open the option to consider issues not even raised at all in the Court below under appropriate circumstances. Here the issue was both raised in and decided by the Court below.

The case of California v. Taylor, 353 U.S. 553, 556 n. 2d (1957), is of the same nature as the prior two cases. This Court noted in that case that the Court of Appeals had "held that this contention had been waived because it was not briefed there by the state and not mentioned in the state's oral argument." The distinguishing fact between this case and the prior cases is that in Taylor the Court of Appeals had specifically found the issue to have been waived because it had not been briefed or argued before it. Once again, Section 1870.05(B) was both argued and decided by the Court of Appeals and is properly before this Court.

The Respondents-Cross-Petitioners place primary reliance on the case of O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 783 n. 14 (1980).

In O'Bannon, it was urged that the petition be dismissed as the petitioners had not appealed the District Court decision. This Court declined to dismiss the petition. While this Court did not allow the state agency to address the issue that it continue paying its share of benefits, the petitioners were allowed to present the main issue of the petition. As the state agency had a sufficient interest in the question to give it standing to argue the merits, there was no need for the state agency to file an appeal in the Court of Appeals in order to keep the issue alive, and the argument had been vigorously asserted by the federal agency in the Court of Appeals and fully addressed there. The above criteria are all satisfied in the present case. Further, this Court decided in O'Bannon that a party to proceedings in the Court of Appeals who had argued the merits of the major issue presented in a petition for certiorari is automatically joined as respondent in the Supreme Court when a party who was also an appellee files the petition for certiorari, and in such capacity as an automatically joined respondent, the party may seek reversal of the judgment of the Court of Appeals on any ground urged in that court. Thus, the Defendant-Intervenors, who appealed the District Court's holding as to Section 1870.05(B), are automatically joined respondents and may seek

reversal of the Court of Appeals decision.

Section 1870.05(B) is capable of a construction that would render it constitutional. It is not to be assumed that an Ohio juvenile court proceedings will construe the ordinance in a manner inconsistent with the constitutional requirements. Thus, as noted by Judge Kennedy in her dissenting opinion, Section 1870.05(B) is not facially invalid. (App. 33a). As no minor challenges Section 1870.05(B), no party before this Court has standing to challenge the section, and it is premature to hold it unconstitutional. This Court has consistently refused to strike down legislation on its face without a state court determination as to construction and application of the laws. H.L. v. Matheson, 450 U.S. 398, 407 (1981), and Bellotti v. Baird, 443 U.S. 622 (1979). In order to have standing to challenge Section 1870.05(B) as applied, it must be challenged by a minor under the age of fifteen who alleges she is mature or emancipated. Thus, the decision of the lower court should be reversed.

Even if this Court should find Petitioners waived their right to appeal the issue of Section 1870.05(B)'s constitutionality, the Petitioners cannot waive the question of standing or the rights of Defendants-Intervenors.

III. THE STATE HAS A LEGITIMATE

INTEREST IN INSURING INFORMED CONSENT.

Section 1870.06(B) is constitutional in its entirety as it serves the important state interests of protecting the woman's health and assuring that a woman's freedom to choose to have an abortion or to decide to carry the child to term will be truly informed. Contrary to Respondent-Cross-Petitioner's assertions that the City of Akron has conceded that Subsections (3), (4), and (5) are unconstitutional, the City maintains that these subsections are constitutional in their entirety.

The District Court in holding the section unconstitutional incorrectly placed the burden of proving the facts contained therein to be true on the Defendants. (App. 95a). It was incumbent upon the Plaintiffs to show that the facts were not true. The District Court, however, made no findings of fact regarding the subsections involved. Its decision was simply based upon its ruling that the state cannot "specify what each patient must be told." (App. 96a). In so deciding, the District Court noted the desire to insure that a woman's consent to an abortion is truly informed is a valid state interest. (App. 95a).

Section 1870.06(B) requires that the attending physician inform a woman prior to an abortion of several factors.

Subsection (3) requires that the woman be informed that the unborn child is a human life. (App. 121a). Such a statement is clearly factual. (App. 121a). To contend that the unborn fetus is not human life ignores the obvious. The fetus is alive and growing. Otherwise, there would be no need for the woman to make the choice.

Subsection (4) requires the physician to inform the woman that the unborn child may be viable if more than twenty-two weeks have elapsed from the time of conception. (App. 121a). Again, this is a factual statement. It is relevant information to a woman who is pregnant to know at what point the fetus may be viable. It is a fact relating to her pregnancy of which she should be made aware. It is for the woman, in consultation with her physican, to decide whether or not to terminate her pregnancy.

Subsection (5) requires that the woman be informed that an abortion is a major surgical procedure which can result in serious complications. (App. 121a). The testimony at trial was conflicting on this statement. While it is subject to medical debate, such complications do occur. The physican, while informing the woman of the complications, is free to express his opinion as to the likelihood of such complications occurring.

Contrary to Respondent's allegations in the

courts below, nothing in Section 1870.06(B) denies the physican flexibility, as Section 1870.06(C) expressly permits the physician to:

> . . . provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term. (emphasis added)

The requirements of Section 1870.06(B) protect the woman's constitutionally protected right to decide whether or not to terminate her pregnancy. To reach such a decision it is necessary that she be well informed. The provision strikes a reasonable balance between the woman's right of privacy and the state's interest in maternal health and ensuring the informed consent of the patient. Maher, supra, 432 U.S. at 473.

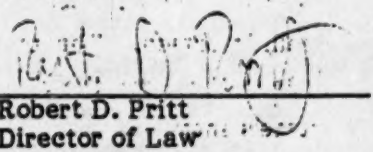
Rather than burdening the decision, this information in fact enhances the woman's ability to make an informed choice.

CONCLUSION

Therefore, the appropriate disposition of this case is to reverse the decision of the Court of Appeals as to Sections 1870.06(C) and 1870.07 and remand for an affirmance of the decision of the District Court as to those sections. As to Sections 1870.05(B), 1870.6(B) and 1870.16, the decision of the Court of Appeals should be reversed.

Dated November 22, 1982.

Respectfully submitted,



Robert D. Pritt
Director of Law
The City of Akron
304 Municipal Building
Akron, OH 44308-1655
(216) 375-2031

Attorney for Petitioner

OF COUNSEL:

Karen L. Edwards-Smith
9821 Olde Eight Road
Northfield, OH 44067
(216) 467-8571

Alan G. Segedy
40 E. Mill St.
Akron, OH 44308
(216) 253-5535

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Nos. 81-746 and 81-1172

In the Supreme Court of the United States

October Term, 1982

CITY OF AKRON,
Petitioner,

vs.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC. *et al.*,
Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC. *et al.*,
Cross-Petitioners,

vs.

CITY OF AKRON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENTS' AND CROSS-PETITIONERS' REPLY BRIEF

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328
(*Counsel of Record*)

LOIS J. LIPTON
Roger Baldwin Foundation of A.C.L.U. Inc.
220 South State Street
Chicago, Illinois 60604

GORDON BEGGS
American Civil Liberties Union of Cleveland Foundation, Inc.
1223 West Sixth Street
Cleveland, Ohio 44113

Attorneys for Respondents and Cross-Petitioners

THE GATES LEGAL PUBLISHING CO., CLEVELAND, OHIO—TEL. (216) 621-5647

TABLE OF CONTENTS

TABLE OF AUTHORITIES II
ARGUMENT 2

I. The Record Demonstrates That Free-Standing Clinics Are Medically Appropriate for the Performance of Second Trimester Abortions and Further Demonstrates the Burdens Created by an Outright Ban on Second Trimester Abortions in Such Facilities 2

II. Defendants Have Demonstrated Neither That the J.C.A.H. Hospital Requirement Imposed by Section 1870.03 Serves a Compelling State Interest nor That It Is Narrowly Drawn 4

III. Requiring Persons to Travel in Order to Exercise Their Constitutional Rights Has Been Rejected by This Court 6

CONCLUSION 8

TABLE OF AUTHORITIES

Cases

Doe v. Bolton, 410 U.S. 179 (1973) 6

Gary-Northwest Indiana Women's Services, Inc. v. Bowen, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934 (1981) 4

Mississippi University for Women v. Hogan, ... U.S. ....., 102 S.Ct. 3331 (1982) 7

Planned Parenthood Association of Kansas City, Missouri v. Ashcroft, 655 F.2d 848; *supplemented* 664 F.2d 687 (8th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (U.S. May 24, 1981) (Nos. 81-1255, 81-1623) 2

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 4, 5

Roe v. Wade, 410 U.S. 113 (1973) 5

Shad v. Borough of Mount Ephraim, 452 U.S. 61 (1981) 7

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENTS' AND CROSS-PETITIONERS' REPLY BRIEF

ARGUMENT

I. THE RECORD DEMONSTRATES THAT FREE-STANDING CLINICS ARE MEDICALLY APPROPRIATE FOR THE PERFORMANCE OF SECOND TRIMESTER ABORTIONS AND FURTHER DEMONSTRATES THE BURDENS CREATED BY AN OUTRIGHT BAN ON SECOND TRIMESTER ABORTIONS IN SUCH FACILITIES.*

Plaintiffs in the present case and in the case of *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft,* 655 F.2d 848; *supplemented* 664 F.2d 687 (8th Cir. 1981), *cert. granted,* 50 U.S.L.W. 3934 (U.S. May 24, 1981) (Nos. 81-1255, 81-1623), as well as amici American College of Obstetricians and Gynecologists (A.C.O.G.) and American Medical Association have detailed for this Court the scientific evidence demonstrating that second trimester abortions are safer than childbirth[1] and that such abortions may be as safely performed in free-standing clinics as in hospitals.[2]

The defendants have offered virtually no scientific evidence to support their requirement, set forth in ordi-

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*The designations used in this Brief to refer to documents filed with this Court are those set forth in Respondents and Cross-Petitioners' Brief at 2 n. 1.

1. On the question of mortality risks see Respondents and Cross-Petitioners' Brief at 10 and materials cited therein; Brief of Amici A.C.O.G., *et al.*, at 21 and materials cited therein. (By 1977 the death-to-case rate for second trimester abortion was 6.5 per 100,000 while that for childbirth was 9.3 per 100,000.)

2. On the question of the safety of free-standing clinics see Respondents and Cross-Petitioners' Brief at 10-11 and n. 20; L. Doc. 3, p. 406, Ash. A. 85; Brief of Amici A.C.O.G., et al., at 23 and n. 64; Brief of Respondent in *Planned Parenthood v. Ashcroft* at 4-10 and testimony cited therein.

nance Section 1870.03, that all second trimester and later abortions be performed in a J.C.A.H. accredited hospital. Rather, defendants have placed almost total reliance on an A.C.O.G. requirement that was abrogated in 1982 and replaced by a specific endorsement of the performance of second trimester abortions in free-standing clinical facilities up to 18 weeks from the last menstrual period.[3] Both the American Public Health Association[4] and the Planned Parenthood Federation of America[5] have also concluded that early second trimester abortions should be permitted in free-standing clinical facilities.

The court of appeals in the present case found, and defendants do not seriously dispute, that the effect of imposing an in-hospital requirement is to force up to ten percent of women seeking abortions in Akron to travel to facilities as far away as the State of Michigan or, if travel is impossible, to face the prospect of "carrying the baby to term, attempting self-abortion or seeking illegal abortions" (Pet. A. 19a). The court of appeals also found, and defendants do not dispute, that hospitalization increases the cost of abortion by as much as $550 (Pet. A. 20a). As the court of appeals concluded "without the ability to travel and funds to pay for the hospital treatment, many of these Akron women have no real opportunity to obtain an abortion" (Pet. A. 20a).

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3. The text of the A.C.O.G. standard is set forth as Appendix B to Respondents and Cross-Petitioners' Brief in the present case.

4. The text of the American Public Health Association standard is set forth as Appendix C to Respondents and Cross-Petitioners' Brief.

5. The text of the Planned Parenthood Federation of America standard is set forth as Appendix D to Respondents and Cross-Petitioners' Brief.

II. DEFENDANTS HAVE DEMONSTRATED NEITHER THAT THE J.C.A.H. HOSPITAL REQUIREMENT IMPOSED BY SECTION 1870.03 SERVES A COMPELLING STATE INTEREST NOR THAT IT IS NARROWLY DRAWN.

Despite finding that the J.C.A.H. hospital requirement of Section 1870.03 seriously burdens women seeking second trimester abortions, the Sixth Circuit Court of Appeals upheld the regulation. It did so exclusively on the strength of this Court's summary affirmance in *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934 (1981). The Sixth Circuit's reliance on *Gary-Northwest* was based upon a misapprehension of the statutory requirement at issue in that case. Because the Indiana statute defined "hospital" to include out-patient facilities[6] *Gary-Northwest* is simply inapplicable to this case.[7] In contrast to the Indiana statutes, Section 1870.03 flatly prohibits the use of any type of out-patient facility and even prohibits hospitals from performing second trimester abortions unless they have J.C.A.H. accreditation.

In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), a case that defendants ignored in their discussion of Section 1870.03, this Court reviewed a Missouri regulation prohibiting the use of saline amniocentesis

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6. The texts of the relevant Indiana statutes are set forth as Appendix B to Respondent's Cross-Petition for Writ of Certiorari.

7. As noted in Respondents and Cross-Petitioners' Brief at 40 n. 68, the summary affirmance in *Gary-Northwest* is inapplicable for at least two other reasons as well: (1) the questions presented in the jurisdictional statement were primarily procedural; (2) the district court in *Gary-Northwest* found several significant evidentiary failures not present in this case.

as a technique of abortion after the first 12 weeks of pregnancy. This Court applied the compelling interest test in that case. 428 U.S. at 76. *Danforth* concluded that the Missouri regulation was unconstitutional because saline procedures were "commonly used nationally by physicians," were safer "with respect to maternal mortality than even continuation of the pregnancy until normal childbirth," and were likely to force "a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 78-79.

Akron's hospitalization requirement operates in the same way as the Missouri regulation. It prohibits Akron's free-standing clinics from performing early second trimester abortions by the D and E method despite the widespread use of such methods by clinics across the United States.[8] It prohibits clinics from performing abortion procedures that are far less dangerous than childbirth.[9] Finally, as found by the court of appeals, Akron's regulation forces women to pursue alternatives that significantly increase the health risks they face due to increased travel, carrying the pregnancy to term, seeking illegal abortions or attempting self-abortion (Pet. A. 19a-20a). In light of this Court's holding in *Danforth* and the failure of the defendants to provide even that quantum of evidence rejected in *Danforth*, Section 1870.03 is unconstitutional.[10]

Roe v. Wade, 410 U.S. 113 (1973), held that regulations limiting abortion must not only be justified by a

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8. See materials set forth in Brief of Amici A.C.O.G., et al., at 25 n. 70.

9. See note 1 *supra*.

10. In addition to their failure to present sufficient evidence to support the flat prohibition of second trimester abortions in free-standing clinics, defendants themselves state at two places in their Reply Brief (at 5 and 17) that such questions should be decided on a case by case basis rather than by reliance on a flat ban.

compelling state interest but that such "legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." 410 U.S. at 155. In *Doe v. Bolton,* 410 U.S. 179 (1973), this Court invalidated a Georgia regulation requiring that all abortions be performed in hospitals accredited by the J.C.A.H. It was noted in *Doe* that among the "optimum achievable standards" of the J.C.A.H. were requirements for a dietetic service, a written disaster plan for mass emergencies, a nuclear medical services program and a radiology program. 410 U.S. at 193 n. 12. This Court held that such requirements went far beyond any legitimate objective the state might have in the abortion context. *Id.* at 195. In the present case Akron has imposed precisely the same requirement held unconstitutional in *Doe.* Defendants in the present case have failed to demonstrate that a hospital requirement of any sort is justified, nor have they provided any evidence warranting this Court's reversal of its explicit holding in *Doe v. Bolton.* Under these circumstances it is clear that Section 1870.03 is not narrowly drawn to express only a legitimate state interest and should be held unconstitutional.

III. REQUIRING PERSONS TO TRAVEL IN ORDER TO EXERCISE THEIR CONSTITUTIONAL RIGHTS HAS BEEN REJECTED BY THIS COURT.

In their Reply Brief defendants cavalierly suggest that women denied second trimester abortions in Akron should seek them at clinics or hospitals in other localities. Defendants' Reply Brief at 3.[11] Defendants in this case

11. Apparently defendants do not question the safety of second trimester clinic abortions in localities other than Akron.

made absolutely no showing of the availability of second trimester abortion services in nearby communities. Moreover, the only evidence touching on this question indicates that Akron women are forced to travel to facilities as far away as Michigan to obtain second trimester abortions (Pet. A. 19a).

On several occasions in recent years this Court has rejected the argument that constitutional rights may be curtailed so long as they may be exercised elsewhere. Such an argument was advanced by the State of Mississippi in *Mississippi University for Women v. Hogan*, ... U.S. ....., 102 S.Ct. 3331, 3336 n. 8 (1982). This Court rejected the argument and found that compelling plaintiff Hogan to drive a considerable distance to attend nursing classes in another city "disadvantaged" him and resulted in a constitutionally cognizable burden. Similarly, in *Shad v. Borough of Mount Ephraim*, 452 U.S. 61, 76-77 (1981), this Court rejected Mount Ephraim's argument that a broad spectrum of entertainment could be banned because it might be available elsewhere. In this case the travel argument is without merit and should be rejected.

CONCLUSION

For the foregoing reasons, as well as those previously enumerated, this Court should vacate the judgment of the court of appeals holding Section 1870.03 of the Akron ordinance constitutional and remand the issue to that court for further proceedings.

Respectfully submitted,

STEPHAN LANDSMAN
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2328

LOIS J. LIPTON
Roger Baldwin Foundation of
A.C.L.U. Inc.
220 South State Street
Chicago, Illinois 60604

GORDON BEGGS
American Civil Liberties Union
of Cleveland Foundation, Inc.
1223 West Sixth Street
Cleveland, Ohio 44113

Attorneys for Respondents and Cross-Petitioners

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Nos. 81-746 and 81-1172

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On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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BRIEF *AMICI CURIAE* OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, AND THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

M. CAROLYN COX
LYNN BREGMAN *
ANNE H. EGERTON
TILLMAN L. LAY
WILMER, CUTLER & PICKERING
1666 K Street, N.W.
Washington, D.C. 20006
(202) 872-6000
Counsel for *Amici Curiae*

* Counsel of Record

August 27, 1982

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. DETAILED SPECIFICATION OF THE INFORMATION THAT A PHYSICIAN MUST PROVIDE EACH ABORTION PATIENT UNCONSTITUTIONALLY BURDENS THE PATIENT'S RIGHT, IN CONSULTATION WITH HER PHYSICIAN, TO DECIDE WHETHER TO TERMINATE HER PREGNANCY	4
A. The Decision To Terminate Pregnancy Is a Decision To Be Made by the Patient in Consultation with Her Physician	6
B. The Requirement That a Physician Recite a Standard Checklist of Information in All Cases, Regardless of the Circumstances, Significantly Interferes with the Physician-Patient Relationship and May Disserve the Patient's Best Interests	8
C. The Requirement That a Physician Provide Information He Believes To Be Untrue, Without Medical Foundation, or Not in His Patient's Best Interests Serves No Legitimate State Interest	10
II. THE REQUIREMENT THAT ALL MINORS OBTAIN PARENTAL CONSENT OR COURT AUTHORIZATION FOR AN ABORTION IS UNCONSTITUTIONAL	14
III. THE REQUIREMENT THAT ALL SECOND TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONALLY OVERBROAD	17

TABLE OF CONTENTS—Continued

Page

A. Abortion Today, When Performed Prior to the Late Second Trimester, May Be Performed as Safely in a Properly Licensed Nonhospital Facility as in a Hospital 19

B. Akron Has No Cognizable Interest in Requiring That All Second Trimester Abortions Be Performed in Hospitals 26

C. Even If Akron Has a Cognizable Interest in Protecting Maternal Health Throughout the Second Trimester of Pregnancy, the Requirement That All Second Trimester Abortions Be Performed in Hospitals Is Not Reasonably Related to That Interest 27

CONCLUSION 30

TABLE OF AUTHORITIES

CASES: Page

Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979), *aff'd in part and rev'd in part*, 651 F.2d 1198 (6th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (May 24, 1982) (Nos. 81-746 & 81-1172) .. 5, 11, 12, 25, 28

Bellotti v. Baird, 443 U.S. 622 (1979) 14, 15, 16, 17

Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) 8, 9

Carey v. Population Services International, 431 U.S. 678 (1977) 5

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980)..... 14

Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) 9

Colautti v. Franklin, 439 U.S. 379 (1979) 6, 7, 18, 29

Connecticut v. Menillo, 423 U.S. 9 (1975) 7

Doe v. Bolton, 410 U.S. 179 (1973) .....*passim*

Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978), *aff'd mem.*, 440 U.S. 941 (1979) 13

Gary-Northwest Indiana Women's Services v. Bowen, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services v. Orr*, 451 U.S. 934 (1981).. 18

H.L. v. Matheson, 450 U.S. 398 (1981) 13, 15

Harris v. McRae, 448 U.S. 297 (1980) 5

Illinois State Board of Elections v. Socialist Workers Party, 440 U.S. 173 (1979) 19

Leigh v. Olson, 497 F. Supp. 1340 (D.N.D. 1980).. 14

Maher v. Roe, 432 U.S. 464 (1977) 5

Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La. 1980) 14

Mobile v. Bolden, 446 U.S. 55 (1980)..... 5

Planned Parenthood v. Danforth, 428 U.S. 52 (1976) .....*passim*

Planned Parenthood Association of Kansas City v. Ashcroft, 483 F. Supp. 679 (W.D. Mo. 1980), *aff'd in part and rev'd in part*, 655 F.2d 848, *supplemented*, 664 F.2d 687 (8th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (May 24, 1982) (Nos. 81-1255 & 81-1623) 3, 12, 14, 16, 19, 25

TABLE OF AUTHORITIES—Continued

	Page
Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1981)	13, 14
Roberts v. Wood, 206 F. Supp. 579 (S.D. Ala. 1962)	9
Roe v. Wade, 410 U.S. 113 (1973)	*passim*
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

Nos. 81-746 and 81-1172

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Petitioners,

v.

CITY OF AKRON, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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BRIEF *AMICI CURIAE* OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, AND THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF ORSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

INTEREST OF *AMICI CURIAE*

Amici curiae are four major organizations of health care professionals. Each *amicus* is dedicated to promoting the public welfare through the maintenance of high professional standards and the provision of quality health care.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians specializing in obstetric-gynecologic care. ACOG is the leading group of professionals providing health care to women; its 23,000 members represent approximately 90% of all obstetricians and gynecologists practicing in the United States.

Amicus American Medical Association ("AMA") is a private, voluntary, nonprofit organization of physicians. AMA was founded in 1846 to promote the science and art of medicine and the betterment of public health. Today, its membership exceeds 234,700.

Amicus American Academy of Pediatrics ("AAP") is a nonprofit Pan-American Association of approximately 24,000 physicians certified in the care of infants, children and adolescents. AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health. Because of its commitment to the physical and mental wellbeing of our nation's youth, AAP has a particular interest in the parental consent issues discussed in Section II of this brief.

Amicus Nurses Association of The American College of Obstetricians and Gynecologists ("NAACOG") is a private, voluntary, nonprofit organization of 17,000 registered nurses and allied health workers specializing in obstetric-gynecologic nursing care. NAACOG's primary goal is to promote excellence in health care by furthering continuing education and setting standards for nursing practice.

Amici's interest arises from their devotion to the provision of the highest possible quality health care, their dedication to good medical practice, and their commitment to ensuring that patients can freely seek and obtain medical care and that physicians are in a position to discharge their responsibility to provide care and treatment according to their best clinical judgment and professional and ethical standards. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surround-

ing abortion; indeed, their members ascribe to widely divergent views on these issues. The organizations' members, however, share an interest in making certain that, once a patient has made a decision to seek medical care or treatment, such as an abortion, state laws do not unduly interfere with the physician's ability to exercise his best judgment in carrying out the patient's decision in the manner most suited to her particular health needs.[1]

The provisions of the Akron ordinance at issue in this case, like the statutory restrictions under review in other cases pending before the Court,[2] interfere with the free exercise of a woman's right to seek and obtain wanted medical care, prevent her physician from exercising his best professional judgment and providing patients with the best possible medical care, and present a serious obstacle to sound medical practice. Because the outcome of these cases will directly affect the professional services *amici* members provide and the patients whom they serve, *amici* wish to present their views as to the important medical issues raised by the statutory restrictions.[3]

SUMMARY OF ARGUMENT

Akron Ordinance Section 1870.06(B), which requires a physician to recite to his patient, before obtaining her consent to an abortion, seven paragraphs of supposed "facts" unrelated to the medical services being rendered—despite what may be his belief that many of the required statements are untrue, without scientific foundation or contraindicated by his patient's particular needs—unconstitutionally burdens the woman's right, in consultation with her physician and based on his professional opinion,

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[1] Such interest prompted ACOG to file briefs *amicus curiae* in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973).

[2] *See, e.g., Planned Parenthood Ass'n of Kansas City v. Ashcroft* (No. 81-1255); *Ashcroft v. Planned Parenthood Ass'n of Kansas City* (No. 81-1623).

[3] The parties' written consents to the filing of this brief are being filed with the Clerk pursuant to Rule 36 of the Rules of this Court.

to decide whether to terminate her pregnancy and serves no legitimate state interest.

Akron Ordinance Section 1870.05(B), which makes punishable as a crime the performance of an abortion on a minor under fifteen years of age who has not produced the written consent of a parent or a court order, unconstitutionally inhibits the right to seek an abortion by vesting in a third party an absolute veto over the minor's decision even where she is mature enough fully to understand and intelligently to consent to an abortion and by denying a minor whose best interests militate against parental notice access to an independent judicial determination that she is sufficiently mature to consent or that an abortion would be in her best interests.

Akron Ordinance Section 1870.03, which requires that all abortions after the first trimester be performed in hospitals, unconstitutionally interferes with a woman's ability to obtain an abortion and her physician's ability to implement her decision in a manner best suited to her health needs, without providing any discernible safety benefit or serving any compelling health interest to which it is sufficiently narrowly tailored.

ARGUMENT

I. DETAILED SPECIFICATION OF THE INFORMATION THAT A PHYSICIAN MUST PROVIDE EACH ABORTION PATIENT UNCONSTITUTIONALLY BURDENS THE PATIENT'S RIGHT, IN CONSULTATION WITH HER PHYSICIAN, TO DECIDE WHETHER TO TERMINATE HER PREGNANCY.

Akron Ordinance Section 1870.06(B) requires an attending physician to recite to a patient seeking an abortion seven paragraphs of supposed "facts" before obtaining her "informed consent" to the procedure. No discretion or flexibility is permitted: on pain of criminal liability,[4] the physician must "make [the same specified]

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[4] Akron, Ohio, Codified Ordinances ch. 1870, § 1870.18(A) ("Akron Ordinance"). The imposition of criminal sanctions for violation of the provisions of Akron Ordinance Chapter 1870 consti-

disclosures in all cases regardless of his own professional judgment as to the desirability of doing so"[5] and even though he may believe—as most physicians do—that many of the specified "facts" are untrue, unsupported by medical or scientific evidence, contrary to sound medical practice, irrelevant to any conceivable medical purpose, or contraindicated for certain patients. This requirement unduly restricts the exercise of medical judgment by the attending physician and unconstitutionally burdens the woman's right to decide, in consultation with her physician and in accordance with his best medical judgment, to terminate her pregnancy.[6]

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tutes "direct state interference with a protected activity" (*Maher v. Roe*, 432 U.S. 464, 475 (1977)), rather than the sort of "state encouragement of an alternative activity consonant with legislative policy" at issue in *Maher* and *Harris v. McRae*, 448 U.S. 297 (1980). Since "[c]onstitutional concerns are greatest" when, as here, "the State attempts to impose its will by force of law" (*Maher v. Roe*, 432 U.S. at 476) and since Akron's requirements directly "impinge[] upon a fundamental right . . . implicitly secured by the Constitution," they are "presumptively unconstitutional" (*Harris v. McRae*, 448 U.S. at 312, *quoting Mobile v. Bolden*, 446 U.S. 55, 76 (1980)), "may be justified only by compelling State interests, and must be narrowly drawn to express only those interests." *Carey v. Population Serv. Int'l*, 431 U.S. 678, 686 (1977).

[5] *Akron Center for Reproductive Health, Inc. v. City of Akron*, 651 F.2d 1198, 1207 (6th Cir. 1981), *aff'g in part and rev'g in part* 479 F. Supp. 1172 (N.D. Ohio 1979) (*"Akron Center"*).

[6] *Amici* believe that three of the seven paragraphs of Section 1870.06(B)—subsections (3), (4) and (5)—are not properly before the Court because the City essentially conceded their unconstitutionality before the court of appeals. *See* Brief for City of Akron at 9, 35-36 (Feb. 28, 1980). We address Section 1870.06(B) as a whole, however, because the City has suggested to this Court that the section is constitutional in its entirety and because the individual subparts of Section 1870.06(B) are not severable. *See Akron Center*, 651 F.2d at 1207; 479 F. Supp. at 1202-03; *see also Sloan v. Lemon*, 413 U.S. 825, 834 (1973).

A. The Decision To Terminate Pregnancy Is a Decision To Be Made by the Patient in Consultation with Her Physician.

This Court held in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), that a woman has a constitutional right, in consultation with her physician and based on his professional opinion, to decide to terminate her pregnancy free from undue state interference. Those cases emphasized the central role of the physician-patient relationship in the abortion decision:

> The [*Roe*] decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is *inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.*[7]

Recognizing that the physician-patient relationship is the preferred forum for abortion decisionmaking, the Court has invalidated a number of state-imposed restrictions on access to abortion that impermissibly intrude on that relationship.[8] In *Doe*, for example, the Court struck down requirements that all abortions be performed in

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[7] *Roe v. Wade*, 410 U.S. at 165-66 (emphasis added). *See also Planned Parenthood v. Danforth*, 428 U.S. 52, 61 (1976) ("The participation by the attending physician in the abortion decision, and his responsibility in that decision, thus, were emphasized [in *Roe*]"); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) ("*Roe* stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out. . . . *Roe*'s companion case, [*Doe*], underscored the importance of affording the physician adequate discretion in the exercise of his medical judgment").

[8] The Court has recognized the importance of "deference to the ["presumptively valid"] judgment exercised by a qualified professional" in other contexts as well. *See, e.g., Youngberg v. Romeo*, 50 U.S.L.W. 4681, 4684-85 (June 18, 1982).

accredited hospitals, that two other doctors concur in the attending physician's decision that an abortion would be in his patient's best interests, and that a "hospital committee" approve each abortion.[9] In *Planned Parenthood v. Danforth*, 428 U.S. 52, 82-83 (1976), the Court invalidated a provision requiring the attending physician to "preserve the life and health of the fetus" regardless of the stage of his patient's pregnancy. And in *Colautti v. Franklin*, 439 U.S. 379, 382 (1979), the Court found unconstitutionally vague a similar provision that imposed criminal liability on any physician who failed to determine whether there was "sufficient reason to believe that the fetus may be viable" and to employ the technique that "would provide the best opportunity for the fetus to be aborted alive . . . ."[10]

In contrast, the Court has upheld state regulations that recognize the importance of physician-patient consultation,[11] as well as regulations that neither "encumber[] the woman's exercise of [her] constitutionally protected right" because they place no "obstacles in the path of the doctor upon whom she [is] entitled to rely for advice in

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[9] 410 U.S. at 193-95, 198-200, 195-98. The committee requirement, the Court noted, "substantially limit[s]" the "woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it." *Id.* at 197.

[10] The Court held that, by "condition[ing] potential criminal liability on confusing and ambiguous criteria," the statute had a "profound chilling effect" on physicians' willingness to perform certain abortions "in the manner indicated by their best medical judgment." 439 U.S. at 394, 396.

[11] *See, e.g., Connecticut v. Menillo*, 423 U.S. 9, 11 (1975); *cf. Doe v. Bolton*, 410 U.S. at 191-92 (statute requiring that physician's performance of abortion be "based upon his best clinical judgment that an abortion is necessary" read to permit physician to consider "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient" so as to "allow[] the attending physician the room he needs to make his best medical judgment").

connection with her decision" [12] nor "confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." [13] Since *Roe*, the decisions of this Court have repeatedly emphasized that a woman has the right to choose her response to pregnancy upon consultation with a physician who is in a position properly to advise her and to determine, in light of medical ethics and professional standards of care, how best to effectuate her informed decision.

B. The Requirement That a Physician Recite a Standard Checklist of Information in All Cases, Regardless of the Circumstances, Significantly Interferes with the Physician-Patient Relationship and May Disserve the Patient's Best Interests.

The purpose of providing information to a patient about a contemplated medical procedure is to enable the patient to evaluate knowledgeably its risks and benefits and to decide intelligently whether or not to undergo the procedure.[14] Each patient, however, is unique and, consistent with the disclosure of facts necessary to obtain informed consent, a physician must be able to exercise discretion in determining the amount, nature and mode of presentation of the information that should be conveyed to a particular patient under the circumstances presented.[15] "In determining whether and how much he should disclose, the physician must consider the probable

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[12] *Whalen v. Roe*, 429 U.S. 589, 605 n.33 (1977).

[13] *Planned Parenthood v. Danforth*, 428 U.S. at 67 n.8 (upholding a statute that, rather than straitjacketing the physician, required only that the patient "certify in writing her consent to the [abortion] and 'that her consent is informed and freely given and is not the result of coercion' "; *id.* at 65).

[14] *See, e.g., Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. Rev. 628, 630 (1970).

[15] *See, e.g., Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

impact of disclosure on the patient, taking into account his peculiar knowledge of the patient's psychological, emotional and physical condition, and must evaluate the magnitude of the risk, the frequency of its occurrence and the viability of alternative therapeutic measures." *Woolley v. Henderson*, 418 A.2d 1123, 1130 (Me. 1980).[16]

In discharging his responsibility adequately to inform his patient about a contemplated abortion, as with his other professional responsibilities, the physician must be permitted "the room he needs to make his best medical judgment." *Doe v. Bolton*, 410 U.S. at 192.[17] Akron

[16] Just as some patients wish to be informed about every conceivable complication, no matter how remote, that may result from a surgical procedure, others find such information frightening and prefer to be spared the details. *See, e.g.*, Laufman, *Surgical Judgment*, in Christopher's Textbook of Surgery 1459 (L. Davis 9th ed. 1968); Nemiah, *Psychological Aspects of Surgical Practice*, in Surgery: A Concise Guide to Clinical Practice 9 (G. Nardi & G. Zuidema 3d ed. 1972). Indeed, in certain cases there may be valid medical reasons for nondisclosure. *See, e.g., Canterbury v. Spence*, 464 F.2d at 789; *Sard v. Hardy*, 281 Md. 432, 443, 379 A.2d 1014, 1022 (1977); 40 Pa. Stat. Ann. § 1301.103 (Purdon 1982-83 Supp.). For example, when excessive disclosure would result in anxiety, fear, emotional distress or even increased physical pain, a doctor may decide in the exercise of his best professional judgment to tell his patient no more than she wishes to hear. *See, e.g., Roberts v. Wood*, 206 F. Supp. 579, 583 (S.D. Ala. 1962) (disclosure of risks of "a technical nature beyond the patient's understanding" may cause "anxiety, apprehension, and fear . . . [with] a very detrimental effect on some patients"); *Woolley v. Henderson*, 418 A.2d at 1130 (the doctor must decide "whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy"; "full disclosure under some circumstances could constitute bad medical practice"); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (*en banc*) (a patient has a right to decline to be informed about the risks of a proposed medical procedure). *Cf.* Ohio Admin. Code § 3701-47-06 (B) (1975) (pre-abortion counseling "shall not be forced upon the woman").

[17] Indeed, it is the patient's *right* to obtain her doctor's independent judgment about such matters. *See, e.g., Word v. Poelker*, 495 F.2d 1349, 1352 (8th Cir. 1974).

Ordinance Section 1870.06(B) allows a physician none of this room. By spelling out the information that each patient must receive, regardless of her unique needs and the physician's professional judgment as to what is in that patient's best interests, it imposes on the physician exactly the sort of "undesired and uncomfortable strait-jacket" the Court cautioned against in *Danforth.*[18]

C. The Requirement That a Physician Provide Information He Believes To Be Untrue, Without Medical Foundation, or Not in His Patient's Best Interests Serves No Legitimate State Interest.

By denying a patient the independent judgment of her physician and depriving the physician, on pain of criminal prosecution, of the opportunity to administer to the individual needs of his patients, Section 1870.06(B) would be constitutionally objectionable even if the information required to be conveyed were accurate and pertinent. But the required information is not all accurate and pertinent; Section 1870.06(B) thus suffers from infirmities far more serious than merely confining the physician to a prepared speech.

First, Section 1870.06(B) requires the attending physician to convey to his patients information that he—like most physicians—may believe to be demonstrably false.[19] For example, the doctor is required to inform his patient that the fetus may be viable at a gestational age of only 22 weeks,[20] even though there is no scientific or medical

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[18] 428 U.S. at 67 n.8. *Compare* Akron Ordinance § 1870.06(C), which requires only that the physician inform his patient "of the particular risks associated with her own pregnancy and the abortion technique to be employed," including instructions for post-operative care, and provide her "with such other information [as] in his own medical judgment is relevant to her decision."

[19] This raises serious questions under the first amendment. *See Wooley v. Maynard,* 430 U.S. 705 (1977); *West Va. State Bd. of Educ. v. Barnette,* 319 U.S. 624 (1943).

[20] Akron Ordinance § 1870.06(B)(4).

evidence to support this statement and the experience of the profession confirms its inaccuracy.[21]

The doctor also is required to tell his patient that abortion is a "major surgical procedure," [22] despite the fact that most physicians regard abortion, particularly if performed during the first 18 weeks of pregnancy, as a relatively minor surgical procedure.[23] In addition, the doctor is required to tell his patient that abortion can result in "serious complications, including hemorrhage, . . . sterility and miscarriage and prematurity in subsequent pregnancies" and that it may leave unaffected or worsen existing psychological problems or result in "severe emotional disturbances," [24] notwithstanding that there is little or no evidence that a properly performed abortion increases the risk of any such complications.[25] And, in any event, the required recitation of possible complications is grossly misleading in the absence of information as to the frequency with which these complications occur.[26]

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[21] "[O]n an empirical basis the current limits of viability are clear: there is no unambiguous documentation that an infant born weighing less than 601 grams at a gestational age of 24 weeks or less has ever survived." Nat'l Comm'n for the Protection of Human Subjects of Biomedical and Behavioral Research, *Research on the Fetus* 55 (U.S. Dep't of HEW 1975). *See also* Grimes & Cates, *Complications from Legally-Induced Abortion: A Review*, 34 Obstet. & Gynecol. Survey 177, 182 (1979) ("Grimes & Cates").

[22] Akron Ordinance § 1870.06(B)(5).

[23] The district court so found based on the evidence presented at trial. *Akron Center*, 479 F. Supp. at 1203. *See also* nn. 47-55 & nn. 63-65 and accompanying text *infra*.

[24] Akron Ordinance § 1870.06(B)(5).

[25] *See* ACOG, *Important Medical Facts About Abortion* 10 (Patient Information Booklet 1978).

[26] An explanation of remote risks, absent information as to the unlikelihood of their occurrence, "may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse" treatment or may increase "the risks by reason of the physiological results of the apprehension itself." *Salgo v. Leland*

Second, Section 1870.06(B) requires the attending physician to convey, as if it were an established fact, information for which there is no medical foundation. For example, it requires the physician to inform his patient of the "unborn child's" sensitivity to pain, notwithstanding the medical profession's complete ignorance on that subject.[27]

Third, Section 1870.06(B) requires the attending physician prior to performing an abortion to supply information that bears no relevance to the contemplated procedure or to related medical concerns. For example, the section requires the physician to inform his patient that the embryo or fetus is "a human life from the moment of conception" and to describe "in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed," including "appearance, mobility, tactile sensitivity, including pain, percep-

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Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d at 578, 317 P.2d at 181; *see also* n.16, *supra*. Accordingly, courts have traditionally recognized that "[t]he physician need not deliver a 'lengthy polysyllabic discourse on all possible complications'" and that the physician is under no duty "to discuss the relatively remote risks inherent in common procedures." *Sard v. Hardy*, 281 Md. at 444, 445, 379 A.2d at 1022.

Indeed, by its omission, Akron Ordinance Section 1870.06 (B) (5) leaves the erroneous impression that the patient can avoid "serious complications" by forgoing abortion and electing childbirth, an option that actually may pose a greater risk to her health. *See* nn. 49-55 and accompanying text *infra*.

[27] 479 F. Supp. at 1203. The section also requires the physician to inform the patient that she "is" pregnant and of the number of weeks that have elapsed since conception. The effect of these requirements is to prohibit the performance of menstrual extractions to terminate a pregnancy, a procedure performed soon after the first missed menstrual period, since at that time the physician cannot determine conclusively—as Section 1870.06(B) requires him to do—that the patient "is" pregnant. *See Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 483 F. Supp. 679, 697-98 (W.D. Mo. 1980), *aff'd in part and rev'd in part*, 655 F.2d 848, 868-69, *supplemented*, 664 F.2d 687 (8th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (May 24, 1982).

tion and response, brain and heart function, the presence of internal organs and the presence of external members." [28] Both Akron's "theory of life" [29] and the anatomical and physiological description of the embryo or fetus are plainly "irrelevant and extraneous to the medical services being rendered" and contribute in no way to the patient's understanding of the nature of the proposed procedure or to her weighing of the risks and benefits thereof.[30]

There can be no doubt that the intended purpose, and presumably the effect, of Section 1870.06(B) is to discourage patients from obtaining abortions. But the City of Akron has no legitimate interest, compelling or otherwise, in requiring a physician to provide his patient with inaccurate, baseless or irrelevant information that might intimidate and deter her from effectuating her decision to terminate her pregnancy. Section 1870.06(B) thus impermissibly burdens the patient's exercise of her constitutional right, in consultation with her physician, to decide whether and how to terminate her pregnancy and gratuitously encroaches on the physician's exercise of his professional judgment as to the nature and extent of the information his patient needs or desires to make an informed decision. While a narrowly drawn requirement that the patient certify that her decision to have an abortion has been made without coercion may be permissible,[31]

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[28] Akron Ordinance § 1870.06(B)(3).

[29] *Roe v. Wade*, 410 U.S. at 162.

[30] *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978), *aff'd mem.*, 440 U.S. 941 (1979). *See Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981) (striking down a statute requiring the disclosure of information "not directly material to any medically relevant fact, and [that] does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement"). Similarly irrelevant and thus equally objectionable are Sections 1870.06(B)(6) and (7) of the Akron ordinance.

[31] *See Planned Parenthood v. Danforth*, 428 U.S. at 65-67. In a footnote in *H.L. v. Matheson*, 450 U.S. 398, 400 n.1 (1981), the Court

Section 1870.06(B) goes too far in requiring the physician to read a lengthy statement, major portions of which are untrue, without foundation or irrelevant, and even when to do so might be "unwelcome, and medically contraindicated." [82]

II. THE REQUIREMENT THAT ALL MINORS OBTAIN PARENTAL CONSENT OR COURT AUTHORIZATION FOR AN ABORTION IS UNCONSTITUTIONAL.

Akron Ordinance Section 1870.05(B) makes punishable as a crime the performance of an abortion on a minor under fifteen years of age who has not produced the written consent of a parent or a court order. Authorization may be withheld even from a minor who has demonstrated that she "has attained sufficient maturity to make a fully informed decision" regarding termination of her pregnancy. *Bellotti v. Baird*, 443 U.S. 622, 650

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in dictum referred to a Utah informed consent statute. The constitutionality of that statute, however, was not before the Court. Moreover, the Utah statute, which referred in general terms to fetal development and "abortion procedures" and provided for the disclosure of additional information that the physician considered relevant, was substantially less intrusive than Akron Ordinance Section 1870.06(B).

[82] *Planned Parenthood League v. Bellotti*, 641 F.2d at 1022. Significantly, every federal court that has considered similar, detailed recitations that leave the physician no discretion to tailor the information to the particular needs of his patients has held such requirements to be an unwarranted intrusion into the physician-patient relationship and an unconstitutional burden on the exercise of a patient's constitutionally protected right to obtain an abortion on consultation with a physician who is free to exercise his best judgment. *See, e.g., Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 655 F.2d at 866-68 (no review sought); *Planned Parenthood League v. Bellotti*, 641 F.2d at 1018-22; *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980); *Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980); *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980).

(1979).[33] The decisions of this Court in *Planned Parenthood v. Danforth* and *Bellotti v. Baird* leave no doubt that such a regulation, which permits an absolute third party veto, parental or judicial, of a minor's decision to terminate her pregnancy, even where she is mature enough fully to understand and intelligently to make such a decision and to consent to an abortion, is unconstitutional.[34]

Section 1870.05(B) is also constitutionally infirm because, as a practical matter, it requires parental notice of every abortion sought by a minor.[35] Such compulsory

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[33] *See Scheinberg v. Smith*, 659 F.2d 476, 480-81 (5th Cir. 1981) (statute that "does not provide an exception to [best interests] inquiry when the court determines that the minor in question is adequately mature to make the abortion decision herself" vests a court "with constitutionally impermissible discretion to ignore a minor's maturity in determining whether to authorize her abortion").

[34] In *Danforth*, 428 U.S. at 74, the Court held that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy"; in *Bellotti*, 443 U.S. at 647, a plurality of the Court held that "every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents." In *H.L. v. Matheson*, 450 U.S. at 413, the Court upheld a parental notice provision challenged by an unemancipated minor who lived at home and depended on her parents for support, but left open the question whether a parental notice requirement would be constitutional as applied to mature or "best interests" minors. *See id.* at 420 (Powell, J., concurring) ("a State may not validly require notice to parents in all cases, without providing an independent decisionmaker to whom a pregnant minor can have recourse if she believes that she is mature enough to make the abortion decision independently or that notification otherwise would not be in her best interests").

[35] Ohio law, which governs proceedings under the ordinance (Brief for Petitioner City of Akron at 4 n.2, 26), requires that all complaints filed in juvenile court be served on the minor's parents. Ohio Rev. Code Ann. § 2151.28 (Page 1976).

parental notice in all cases denies mature and best interests minors access to judicial proceedings that "will be completed with anonymity and sufficient expedition," [36] and cannot be reconciled with *Bellotti*'s pronouncement that "the constitutional right to seek an abortion may not be unduly burdened by state-imposed conditions upon initial access to court." [37] A mature minor or a minor whose best interests militate against parental notification must be permitted, without parental notification or consultation, to seek an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interests.[38]

Amici recognize the interest in fostering parental consultation and advice "in important decisions by minors." *Bellotti v. Baird*, 443 U.S. at 637. But the physician's primary duty is to his patients, and many minors are sufficiently mature to make reasonable and responsible decisions about their medical needs. Where the reasonably expected parental reaction to such a minor's interest in terminating her pregnancy would be verbal or physical abuse, expulsion from the home or a similar extreme reaction, the minor is entitled to receive medical care without attempting to surmount the obstacle of parental consultation. Indeed, the specter of parental notice in such circumstances may deny the minor medical care and consultation altogether, cause extreme anxiety and mental distress, or result in a delay in seek-

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[36] *Bellotti v. Baird*, 443 U.S. at 644.

[37] *Id.* at 648.

[38] Missouri requires written parental consent or court authorization of an abortion for all minors under eighteen who are not "emancipated." Mo. Ann. Stat. § 188.028 (Vernon Supp. 1982), at issue in *Planned Parenthood Ass'n of Kansas City v. Ashcroft* (No. 81-1255). The Missouri requirement is unconstitutional for the same reasons that Akron Ordinance Section 1870.05(B) is unconstitutional.

ing an abortion that itself may lead to increased health risks or the birth of an unwanted child.[39] For these reasons, *amicus* ACOG has taken the position that professionals working with adolescents should "encourage family involvement whenever feasible," but that "the adolescent should *not* be denied care and services by reason of such considerations."[40] ACOG's view, based upon the experience of its members, is that regulations and "[p]olicies which prevent confidentiality deter adolescents from seeking care, and should be avoided in the interest of health."[41]

III. THE REQUIREMENT THAT ALL SECOND TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONALLY OVERBROAD.

In *Roe v. Wade*, the Court held that, notwithstanding a woman's constitutional right to decide, in consultation with her physician, "whether or not to terminate her pregnancy," abortion implicates certain state interests, including the protection of maternal health, which grow "as a woman approaches term." 410 U.S. at 153, 162-63. Once those interests become " 'compelling,' " the state may regulate the abortion decision in ways reasonably related to its interest. *Id.* at 163.

On the basis of "present medical knowledge" at that time—specifically, the "established medical fact" that "until the end of the first trimester mortality in abor-

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[39] "[T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences." *Bellotti v. Baird*, 443 U.S. at 643.

[40] ACOG, *Statement of Policy: Adolescent Reproductive Health Care* (1979) (emphasis added).

[41] *Id.* As explained to the United States Department of Health and Human Services on April 15, 1982, the position of *amicus* AMA regarding the provision of health care to adolescents and confidentiality policies is virtually identical to ACOG's position. *See also* AAP, Committee on Adolescence, *Pediatrics* 71-73 (1979).

tion may be less than mortality in normal childbirth"—the Court in *Roe* held that the state could regulate the abortion decision to promote its interest in maternal health "[f]or the stage subsequent to approximately the end of the first trimester . . . ."[42] As the Court stated, except when in light of "present medical knowledge," it would be "equally dangerous" for a woman to forgo abortion, "any interest of the State in protecting the woman from an inherently hazardous procedure . . . has largely disappeared." 410 U.S. at 149.

The Court has recognized that "present medical knowledge" changes, and that flexibility in defining the critical points at which state interests become compelling in order to accommodate advances in medical science is essential. With respect to the state's interest in the potential life of the fetus, for instance, the Court has declined to permit the states to establish a specific point of presumptive viability and has instead deliberately "left the [compelling] point flexible for anticipated advancements in medical skill."[43]

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[42] *Id.* at 163-64. *See also Doe v. Bolton*, 410 U.S. 179.

[43] *Colautti v. Franklin*, 439 U.S. at 387. *See also Roe v. Wade*, 410 U.S. at 159-61; *Planned Parenthood v. Danforth*, 428 U.S. at 61, 64.

Despite its conclusions that decisions of other courts finding that the state's maternal health interest does not automatically become compelling at the end of the first trimester are "persuasive" and that the evidence "in the present case was more detailed than that produced" in *Gary-Northwest Indiana Women's Serv. v. Bowen*, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Serv. v. Orr*, 451 U.S. 934 (1981), the court of appeals in this case held, on the basis of the summary affirmance of *Gary-Northwest*, that no such flexibility exists and that the beginning of the second trimester is a "bright line" point at which the state's interest in maternal health automatically becomes compelling. 651 F.2d at 1210. The court erroneously overlooked the fact that, as one of its bases for affirmance, the state in *Gary-Northwest* relied upon the district court's finding that "Plaintiff's [legal] theory, even if accurate, lacked sufficient evidence to support it" (Appellee's Motion to Affirm at 4), so that the issue of whether

In the nine years since *Roe* was decided, medical knowledge has progressed dramatically and, now, "more is known about the morbidity and mortality of induced abortion than any other surgical procedure." [44] Measured as it must be "in the light of present medical knowledge," [45] Akron Ordinance Section 1870.03, requiring that all abortions after the first trimester be performed in hospitals, cannot stand.[46]

A. Abortion Today, When Performed Prior to the Late Second Trimester, May Be Performed as Safely in a Properly Licensed Nonhospital Facility as in a Hospital.

Abortion today, while perhaps politically controversial, is a remarkably safe medical procedure. A patient undergoing an abortion faces about the same risk of death as does a patient receiving an intra-muscular injection of penicillin for gonorrhea.[47] A tonsillectomy is twice as risky, and an appendectomy is nearly a hundred times as risky, as a legal abortion.[48]

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the beginning of the second trimester forms a "bright line" was "by no means adequately presented to and necessarily decided by this Court." *Illinois State Bd. of Elections v. Socialist Workers Party*, 440 U.S. 173, 183 (1979).

[44] Grimes & Cates at 177.

[45] *Roe v. Wade*, 410 U.S. at 163; *Planned Parenthood v. Danforth*, 428 U.S. at 61.

[46] The same is true of Missouri statute § 188.025 under consideration in *Ashcroft v. Planned Parenthood Ass'n of Kansas City* (No. 81-1623). Mo. Ann. Stat. § 188.025 (Vernon Supp. 1982).

[47] Grimes, *Abortion and Health: Past, Present and Future* 5 (Mar. 7, 1981) (Paper prepared for Health Care Commission, American College of Obstetricians and Gynecologists). From 1972 through 1978, the death-to-case rate for legal abortions was 2.2 deaths per 100,000 procedures; the rate for penicillin injections administered to gonorrhea patients was 2 deaths per 100,000 injections. *Id.*

[48] *Id. See also* Wennberg, *The Need for Assessing the Outcome of Common Medical Practices*, 1 Ann. Rev. Pub. Health 277 (1980).

Legal abortion is also safer than childbirth. While the mortality rates for both childbirth and abortion are quite low and on the decline, the mortality rate for abortion is declining at a faster pace.[49] As a result, the risk of death from childbearing, which was five times the risk of death from legal abortion between 1972 and 1975,[50] grew to ten times the risk of death from legal abortion between 1976 and 1978.[51] And while childbirth was the more frequent response to pregnancy, it is still significant that, on average, approximately three times as many women died from childbearing each year between 1972 and 1978 than the total number of women who died from legal abortions in all those years combined.[52]

The mortality rate for second trimester abortions has also fallen dramatically since *Roe v. Wade* was decided.[53]

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[49] LeBolt, Grimes & Cates, *Mortality From Abortion and Childbirth: Are the Populations Comparable?*, 248 J. A.M.A. 188, 189-90 (1982) ("LeBolt, Grimes & Cates"). *See also* Cates, Rochat, Grimes & Tyler, *Legalized Abortion: Effect on National Trends of Maternal and Abortion-Related Mortality (1940 through 1976)*, 132 Am. J. Obstet. & Gynecol. 211 (1978).

[50] Cates, Smith, Rochat & Grimes, *Mortality From Abortion and Childbirth: Are the Statistics Biased?*, 248 J. A.M.A. 192 (1982) ("Cates, Smith"); Cates & Tietze, *Standardized Mortality Rates Associated with Legal Abortion: United States, 1972-1975*, 10 Fam. Plan. Persp. 109 (1978); Cates, Grimes, Smith & Tyler, *Legal Abortion Mortality in the United States: Epidemiologic Surveillance, 1972-1974*, 237 J. A.M.A. 452 (1977).

[51] LeBolt, Grimes & Cates at 190.

[52] *Id.* at 189. In 1972 alone, for instance, nearly 500 women died from childbearing whereas only 138 women died from legal abortions in the seven-year period between 1972 and 1978. *Id.*

Moreover, recent studies show that the mortality rate for childbirth, unlike that for legal abortions, may be underestimated by 25-50%. Cates, Smith at 193-95; Rubin, McCarthy, Shelton, Rochat & Terry, *The Risk of Childbearing Re-Evaluated*, 71 Am. J. Pub. Health 712 (1981).

[53] It is important to note that current medical knowledge and practice regarding abortion demonstrate that the risk of abortion increases only linearly, and not exponentially, as gestational age increases. *See* Grimes & Cates at 177.

Between 1972 and 1975, the death-to-case rate for second trimester abortions ranged between 17.6 and 11.4 per 100,000 procedures; by 1977, it had fallen to 6.5.[54] In contrast, the death-to-case rate for childbirth, which hovered between 15.2 and 10.4 per 100,000 live births between 1972 and 1975, had fallen to 9.3 by 1977.[55]

A principal reason for the increased safety of abortions after the first trimester has been the widespread adoption of dilatation and evacuation ("D&E") as an accepted technique for second trimester abortion.[56] In essence, D&E is a modified application of first trimester curettage techniques (dilatation and curettage and suction curettage) to second trimester abortions,[57] and differs significantly from instillation methods[58] which, until 1978, were the most common technique for performing second trimester abortions.[59]

D&E offers two distinct advantages over instillation as a procedure for second trimester abortions. First, it is

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[54] Benditt, *Second-Trimester Abortion in the United States*, 11 Fam. Plan. Persp. 358 (1979) ("Benditt").

[55] Cates, Smith at 195.

[56] *See* Benditt at 358; Tyler, Cates, Schulz, Selik & Smith, *Second-Trimester Induced Abortion in the United States*, in Second Trimester Abortion 13, 18-20 (1981) ("Tyler, Cates").

[57] *See generally* J. Pritchard & P. MacDonald, Williams Obstetrics 603-07 (16th ed. 1980) ("Pritchard & MacDonald"); Benditt at 359.

[58] Instillation methods, also known as amniotic infusion, involve the artificial induction of labor through transabdominal, intraamniotic injection of an abortifacient solution, such as saline or prostaglandin, and delivery of the aborted fetus, usually within 12 to 36 hours of the injection. *See* Dep't of Med. & Pub. Affairs, Geo. Washington Univ. Med. Center, *Pregnancy Termination in Midtrimester—Review of Major Methods*, Population Rep., Series F, No. 5 pp. F-65, F-66-67 (Sept. 1976); Pritchard & MacDonald at 608-11; Grimes, Schulz, Cates & Tyler, *Methods of Midtrimester Abortion: Which Is Safest?*, 15 Int'l J. Gynaecol. Obstet. 184, 186 (1977) ("Grimes, Schulz").

[59] Cates & Grimes, *Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities*, 58 Obstet. & Gynecol. 401 (1981) ("Cates & Grimes").

safer,[60] in large part due to its unique efficacy for early second trimester abortions performed between 13 and 16 gestational weeks.[61] Second, D&E is more acceptable to

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[60] D&E carries a significantly lower risk of mortality and complications than instillation procedures. *See, e.g.*, Cates & Grimes at 404; Cadesky, Ravinsky & Lyons, *Dilation and Evacuation: A Preferred Method of Midtrimester Abortion*, 139 Am. J. Obstet. & Gynecol. 329 (1981); Hubacker, *Dilatation and Extraction for Late Second-Trimester Abortion*, 15 Advances in Planned Parenthood 119, 122 (1981); Grimes, Hulka & McCutchen, *Midtrimester Abortion by Dilatation and Evacuation Versus Intra-amniotic Instillation of Prostaglandin $F_{2\alpha}$: A Randomized Clinical Trial*, 137 Am. J. Obstet. & Gynecol. 785 (1980) ("Grimes, Hulka & McCutchen"); Grimes & Cates at 188; Cates, *D&E After 12 Weeks: Safe or Hazardous?*, 13 Contemp. Ob/Gyn 23 (1979) ("Cates"); Grimes, Schulz at 137; Grimes, Schulz, Cates & Tyler, *Mid-Trimester Abortion by Dilatation and Evacuation*, 296 New Eng. J. Med. 1141 (1977).

[61] Cates, Schulz, Grimes & Tyler, *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Plan. Persp. 266, 268 (1977) ("Cates, Schulz").

Because of the small size of the amniotic sac, instillation procedures generally cannot be performed until the sixteenth or seventeenth week. Cates, Schulz at 268; H. Holtrop & R. Waife, *Uterine Aspiration Techniques in Family Planning* 18 (1976); Burnett, King, Burkman & Atienza, *An Evaluation of Abortion: Techniques and Protocols*, 10 Hosp. Prac. 97, 101 (1975). By enabling physicians to perform earlier abortions that, using instillation methods, would have had to have been postponed until the sixteenth week, D&E has provided the means to reduce the risk of abortion.

Experience during the 1970s reflects this advance. Between 1973 and 1978, the percentage of second trimester abortions performed between weeks 13 and 15 increased significantly while the percentage performed after week 15 fell. *See* U.S. Dep't of Health & Human Services, Center for Disease Control, *Abortion Surveillance—Annual Summary 1978* iv (1980); Henshaw, Forrest, Sullivan & Tietze, *Abortion in the United States, 1978-1979*, 13 Fam. Plan. Persp. 6, 17 (1981) ("Henshaw, Forrest 1978-79"); Tyler, Cates at 18. During this same period, the percentage of second trimester abortions performed by D&E increased while the percentage performed by instillation declined and, by 1977, D&E surpassed saline instillation as the most frequently used second trimester procedure. Grimes & Cates, *Dilatation and Evacuation*, in Second Trimester Abortion 119, 120 ("Dilatation and Evacuation").

second trimester abortion patients than instillation procedures because it is quicker, less expensive, less painful and less emotionally traumatic.[62] And because D&E eliminates the prolonged labor associated with instillation procedures, it typically can be performed safely on an outpatient basis at either a hospital or a clinic.[63]

Recognition of the fact that most second trimester abortions are as safe as or safer than childbirth has led to a change in the views of many physicians regarding the advisability of hospitalization for all second trimester abortions. There is now sufficient evidence and experience with the D&E technique in particular to demonstrate that, up to at least 16 weeks, abortions performed by physicians in nonhospital facilities are at least as safe as those performed in hospitals.[64] Moreover, based on the experience of its members, *amicus* ACOG recommends in its *Standards for Obstetric-Gynecologic Services* that "[i]n a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility,

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[62] ACOG, *Methods of Midtrimester Abortion*, Tech. Bull. No. 56 (Dec. 1979); Rooks & Cates, *Emotional Impact of D&E vs. Instillation*, 9 Fam. Plan. Persp. 276-77 (1977); Grimes, Hulka & McCutchen at 789.

[63] *See, e.g.*, Cates at 28; Pritchard & MacDonald at 603; Dilatation & Evacuation at 121.

[64] Grimes, Cates & Selik, *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30-32 (1981); Cates & Grimes at 406-07; Grimes, Cates & Tyler, *Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities*, 51 Obstet. & Gynecol. 323 (1978). *See also* Cates, Schulz, Grimes, Horowitz, Lyon, Kravitz & Frisch, *Dilatation and Evacuation Procedures and Second-Trimester Abortions*, 248 J. A.M.A. 559 (1982). Indeed, nonhospital facilities actually enjoy a lower death-to-case rate than hospitals. Cates & Grimes at 404, 406. When adjusted for confounding factors such as the greater tendency of hospital abortion patients to have preexisting conditions and to undergo concurrent sterilization, however, the death-to-case rate for hospital abortions is equivalent to that for nonhospital abortions. *Id.*

abortions should be limited generally to 18 weeks from the last menstrual period." [65]

The decision where an abortion is to be performed—like the decision as to the procedure to be used—should be made in accordance with the patient's desires and the physician's medical judgment.[66] There are a number of reasons why a patient might choose, and a physician might recommend, that an abortion be performed in a nonhospital facility. Hospitalization, for instance, often entails "emotional and financial stresses." [67] In addition, nonhospital facilities frequently provide more extensive counselling services for the abortion patient and more specialized staff. Because most second trimester abortions can be performed as safely in a properly equipped and staffed nonhospital facility as in a hospital, a nonhospital abortion thus will often be in the patient's best interest. Requiring all second trimester abortions to be performed in hospitals therefore interferes with the physician's exercise of his best medical judgment in carrying out his patient's abortion decision in a manner best suited to her individual health and personal needs without offering any discernible safety benefit.

Moreover, a woman in the second trimester of pregnancy who wishes to have an abortion may also have

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[65] ACOG, *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) ("*ACOG Standards*"). ACOG's standards for "free-standing surgical facilities" recommend that they "be licensed to conform to requirements of state or federal legislation" and "maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Id.* at 52. "Surgical procedures may be performed in those facilities under general or regional block anesthesia when it is expected that the postoperative recovery will permit discharge on the same day. There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication." *Id.*

[66] *See* n. 77, *infra*.

[67] *ACOG Standards* at vii.

difficulty implementing her decision in the face of a hospitalization requirement.[68] Akron Ordinance Section 1870.03, for example, has the practical effect of severely limiting a woman's ability to obtain a second trimester abortion in that city.[69] As a result, a woman seeking a second trimester abortion in Akron is likely to face the choice of carrying to term, traveling elsewhere for her abortion, or undergoing an illegal abortion. Each such option poses a greater risk to a woman's health than undergoing an abortion at a properly equipped and staffed nonhospital abortion facility in Akron.[70]

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[68] Less than 30% of all short-term general non-Catholic hospitals in the United States provide abortion services, and the percentage continues to decline. Henshaw, Forrest 1978-79 at 14; Henshaw, Forrest, Sullivan & Tietze, *Abortion Services in the United States, 1979 and 1980*, 14 Fam. Plan. Persp. 5, 12 (1982) ("Henshaw, Forrest 1979-80"). *See also* Nathanson & Becker, *Obstetricians' Attitudes and Hospital Abortion Services*, 12 Fam. Plan. Persp. 26 (1980). Moreover, nearly two-thirds of those hospitals providing abortion services do not provide second trimester abortions. Henshaw, Forrest 1979-80 at 14.

[69] As the court of appeals found, the "unrebutted testimony" showed that "there were only two hospitals in Akron in which second trimester abortions were being performed." *Akron Center*, 651 F.2d at 1209. "During the year preceding trial, only nine such abortions were performed in these two hospitals" while "approximately 10% of the 6000 women who sought abortions at the Akron clinics during the same period were in their second trimester of pregnancy." *Id.*

[70] The ability of freestanding clinics to provide "safe abortions in a supportive setting" has been clearly established. Am. Pub. Health Ass'n, *APHA Recommended Program Guide for Abortion Services (Revised 1979)*, 70 Am. J. Pub. Health 652, 654 (1980). *See also* n. 64, *supra*. Moreover, such facilities have become the major abortion provider, performing nearly 80% of all abortions. Henshaw, Forrest 1979-80 at 5. While freestanding abortion facilities also perform 33% of second trimester abortions (Henshaw, Forrest 1978-79 at 7), a considerably higher percentage of such abortions could be performed safely in those facilities but for the existence of hospitalization requirements such as Section 1870.03. *See Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 664 F.2d

B. Akron Has No Cognizable Interest in Requiring That All Second Trimester Abortions Be Performed in Hospitals.

Medical science has made many advances since the late 1960s and early 1970s, and it is no longer an "established medical fact" that mortality in abortion is less than mortality in normal childbirth only "until the end of the first trimester." *Roe v. Wade*, 410 U.S. at 163. Because it would be "equally dangerous" for a woman to forgo an abortion even well into the second trimester of her pregnancy, any interest the state might have in protecting the woman from an inherently dangerous procedure "has largely disappeared." *Id.* at 149. As the Court has made clear, up until that point, "the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." *Id.* at 166.

In light of the safety of legal abortions, as demonstrated over the past decade, a state's interest in protecting maternal health is adequately served by physician licensing requirements such as are used by states to regulate other medical procedures far more complex and hazardous than abortion.[71] Regulations like Akron's hospitalization requirement that limit access to second trimester abortions, even though such abortions, if performed prior to the sixteenth gestational week, are safer than childbirth, pose a substantial risk of hampering

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at 689 (during the period in which Missouri's statutory hospitalization requirement was "removed" by district court order, nearly half of second trimester abortions in Missouri were performed in non-hospital facilities).

The high percentage of abortions performed in freestanding clinics is part of a larger, general trend in obstetrics and gynecology toward ambulatory health care and out-patient minor surgery. *See, e.g., ACOG Standards* at 51-53; Foster, *Ambulatory Gynecologic Surgery*, in Ambulatory Care in Obstetrics and Gynecology 399 (G. Ryan ed. 1980).

[71] *See* nn. 47-49, *supra*, & n. 77, *infra*.

patients' chances of obtaining abortions at precisely the point in their pregnancies at which it may be in their health interests to do so and deprive patients of the independent judgment of their physicians as to the best choice between equally safe facilities for the performance of abortions best suited to their individual needs.

C. Even If Akron Has a Cognizable Interest in Protecting Maternal Health Throughout the Second Trimester of Pregnancy, the Requirement That All Second Trimester Abortions Be Performed in Hospitals Is Not Reasonably Related to That Interest.

Even if the Court should conclude that, present medical knowledge notwithstanding, a state's interest in maternal health automatically becomes compelling at the beginning of the second trimester, Akron's hospitalization requirement is not reasonably related to that interest or sufficiently "narrowly drawn to express only the legitimate state interests at stake." [72] Instead, it is an overbroad restriction of a woman's right to decide, in consultation with her physician, whether to terminate her pregnancy.

In *Roe*, the Court suggested in dictum that a state may regulate the facilities in which second trimester abortions are performed.[73] In *Doe*, however, the Court made clear that, even with respect to hospitalization requirements, it is the state's burden to prove "that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." [74] Indeed, the Court in *Doe* held that a statutory

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[72] *Roe v. Wade*, 410 U.S. at 155.

[73] *Id.* at 163.

[74] 410 U.S. at 195. In *Doe*, the Court struck down a hospital requirement that "fail[ed] to exclude the first trimester." *Id.* This determination stemmed not from any finding that second trimester hospitalization requirements were, as a matter of law, reasonably related to maternal health, but rather from the dearth of evidence concerning the relative safety of post-first trimester abortions that existed at that time.

The Court has found other second trimester regulations similarly not reasonably related to maternal health. In *Planned Parenthood*

requirement that all abortions be performed in JCAH-accredited hospitals was unconstitutional even as applied to post-first trimester abortions because it was not reasonably related to maternal health.[75]

Akron's blanket hospitalization requirement likewise must fall. The City has not demonstrated that "only the full resources of a licensed hospital" would satisfy its health interests. ACOG's 1974 recommendation that second trimester abortions be performed in hospitals—a standard on which the City relied at trial—has been revised to reflect the current view of the medical profession that many second trimester abortions can be performed as safely in appropriate nonhospital facilities as in hospitals.[76] The Akron ordinance is not reasonably related to maternal health because it lacks foundation in light of current medical practice and knowledge, because it locks physicians into outmoded standards of care, and because no evidence exists that it provides any incremental safety benefit beyond that already provided by state physician licensing requirements.[77]

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v. Danforth, 428 U.S. at 77-79, it held that a statute proscribing second trimester abortion by saline amniocentesis was unconstitutional because the state failed to show that other, safer second trimester abortion procedures were available.

[75] 410 U.S. at 193-94. On this basis alone, Akron's hospitalization requirement is constitutionally infirm since Section 1870.01(B) defines "hospital" to include only those hospitals accredited by JCAH or by the American Osteopathic Association. *Akron Center*, 479 F. Supp. at 1208.

[76] *See* pp. 23-24, *supra*. The revision was occasioned by "[n]ew information on the expanded role of ambulatory health care in obstetrics and gynecology, in addition to ongoing changes necessitated by numerous societal and scientific advances since publication of the last edition in 1974 . . . ." *ACOG Standards* at vii.

[77] It also should be noted that hospitalization requirements for abortion lack rationality when considered in light of the manner in which states and municipalities generally treat other medical procedures, including those of comparable risk and those of far greater risk than abortion. Akron, for instance, does not require by law that any other procedure—whether childbirth, setting a

The Akron ordinance interferes significantly with a woman's ability to exercise her constitutional right to decide whether or not to terminate her pregnancy. First, as the record in this case demonstrates, it has the practical effect of severely limiting a woman's ability to obtain a second trimester abortion in Akron. Since abortion at that point is as safe as or safer than childbirth, the ordinance thus forces a woman to choose between alternatives—either childbirth, an illegal abortion, or traveling to a place where a legal abortion may be obtained—that are in many cases "more dangerous to her health than the method outlawed." [78] And, second, it interferes with a woman's right to consult with her physician by denying the physician "the room he needs to make his best medical judgment," [79] including making the determination that a properly equipped nonhospital facility is preferable for a particular patient's overall health and wellbeing.[80]

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fractured limb, or delicate brain surgery—be performed in a hospital.

Whether hospitalization is required in any given case is a judgment that a physician "is called upon to make routinely whenever surgery is considered." *United States v. Vuitch*, 402 U.S. 62, 72 (1971). Any suggestion that physicians will exercise poor judgment in deciding when an abortion patient should be hospitalized is "degrading to the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients." *Doe v. Bolton*, 410 U.S. at 196-97. "He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called 'error,' and needs." *Id.* Absent evidence that physicians are peculiarly likely to exercise poor judgment in deciding whether to hospitalize abortion patients, there is no "constitutionally justifiable pertinence" in hospitalization requirements. *Id.* at 197.

[78] *Planned Parenthood v. Danforth*, 428 U.S. at 79.

[79] *Doe v. Bolton*, 410 U.S. at 192. *See also Colautti v. Franklin* 439 U.S. at 397.

[80] It thereby places an "obstacle[] in the path of the doctor upon whom she [is] entitled to rely for advice in connection with her [abortion] decision." *Whalen v. Roe*, 429 U.S. at 605 n. 33.

Rather than serving as "a reasonable regulation for the protection of maternal health," [81] Akron's blanket hospitalization requirement is "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." [82]

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals striking down the required informed consent recitation (Section 1870.06(B)) and the parental or judicial consent requirement (Section 1870.05(B)) should be affirmed and the judgment upholding the second trimester hospitalization requirement (Section 1870.03) should be reversed.

Respectfully submitted,

M. CAROLYN COX
LYNN BREGMAN *
ANNE H. EGERTON
TILLMAN L. LAY
WILMER, CUTLER & PICKERING
1666 K Street, N.W.
Washington, D.C. 20006
(202) 872-6000
Counsel for *Amici Curiae*

* Counsel of Record

August 27, 1982

[81] *Planned Parenthood v. Danforth*, 428 U.S. at 79.

[82] *Id.*

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

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v.

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Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

---

BRIEF FOR *AMICUS CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

BRUCE J. ENNIS, JR.
(Counsel of Record)
DONALD N. BERSOFF
ENNIS, FRIEDMAN, BERSOFF & EWING
1200 Seventeenth Street, N.W.
Washington, D.C. 20036
(202) 775-8100
Attorneys for Amicus Curiae *American Psychological Association*

August 27, 1982

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICUS CURIAE*	1
ORDINANCE INVOLVED	2
INTRODUCTION AND SUMMARY OF ARGUMENT	5
ARGUMENT	7
I. EFFECTIVE COUNSELING IS A SKILL WHICH REQUIRES SPECIALIZED KNOWLEDGE AND EXPERIENCE AND ADHERENCE TO RECOGNIZED PRINCIPLES AND TECHNIQUES, INCLUDING RESPECT FOR THE WIDELY VARYING NEEDS OF INDIVIDUAL CLIENTS	7
A. Counseling Is A Recognized Professional Discipline	7
B. In Order To Be Effective, Abortion Counseling Must Be Individually Tailored To Each Woman's Particular Needs	8
C. The Trial Testimony Acknowledged That Physicians Often Lack the Knowledge and Skills Needed For Effective Abortion Counseling	13
II. SECTIONS 1870.06(B) AND (C) OF THE AKRON ORDINANCE PREVENT EFFECTIVE COUNSELING, INTERFERE WITH PROFESSIONAL JUDGMENT, AND UNDULY BURDEN A WOMAN'S CONSTITUTIONAL RIGHT TO MAKE DECISIONS CONCERNING HER PREGNANCY	15
CONCLUSION	23

TABLE OF AUTHORITIES

CASES: Page

Bell v. Wolfish, 441 U.S. 520 (1979) 20
Blue Shield of Virginia v. McCready, —— U.S. ——, 102 S.Ct. 2540 (1982) 2
Colautti v. Franklin, 439 U.S. 379 (1979) 22
Doe v. Bolton, 410 U.S. 179 (1973) 21
Parham v. J.R., 442 U.S. 584 (1979) 20
Planned Parenthood Federation of Central Missouri v. Danforth, 428 U.S. 52 (1976) 21
Roe v. Wade, 410 U.S. 113 (1972) 20
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STATUTES:

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TABLE OF AUTHORITIES—Continued

Page

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TABLE OF AUTHORITIES—Continued

Page

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---

BRIEF FOR *AMICUS CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

The American Psychological Association (APA), a nonprofit scientific and professional organization founded in 1892, is the major association of psychologists in the United States. The APA has more than 55,000 members, and includes the vast majority of psychologists holding doctoral degrees from accredited universites in the United States. The purpose of the APA, as set forth in its by-laws, is to "advance psychology as a science and profession, and as a means of promoting human welfare by the encouragement of psychology in all branches in the broadest and most liberal manner." A substantial and growing number of APA's member psychologists are health-care

providers licensed to provide mental health services to individual clients.

Since 1948, one of APA's major functions has been to accredit doctoral programs in professional psychology. Another of APA's central functions is to establish ethical standards and guidelines for the delivery of psychological services. The Ethical Principles of Psychologists have been incorporated in the laws of most states, thus governing the professional conduct of psychologists licensed in those states.

This case raises the questions of what information should be communicated to pregnant women, and by whom, in the context of pre-abortion counseling. These questions are of particular interest to psychologists because counseling is one of the four recognized specialty areas of professional psychology, and because psychologists would effectively be precluded, under the Akron Ordinance at issue here, from providing pre-abortion counseling.

The APA submits this *amicus brief* in order to bring to the Court's attention relevant professional standards and empirical studies that will not be addressed by the parties.

The APA has frequently participated as an *amicus* in this Court, most recently in *Blue Shield of Virginia v. McCready*, —— U.S. ——, 102 S.Ct. 2540 (1982); and in *Youngberg v. Romeo*, —— U.S. ——, 102 S.Ct. 2452 (1982).

The parties have consented to the filing of this Brief. Their letters of consent have been filed with the Clerk of the Court.

ORDINANCE INVOLVED

Ordinance No. 160-1978, amending Chapter 1870 of the Codified Ordinances of the City of Akron, Ohio, 1975, was adopted by a seven to six vote of the City Council

of Akron, Ohio on February 28, 1978. It will be referred to herein as the "Akron Ordinance." Section 1870.06 of the Akron Ordinance, which is the only section addressed in this *amicus* brief, provides as follows:

> 1870.06 INFORMED CONSENT
>
> (A) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, given freely and without coercion.
>
> (B) In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows:
>
> (1) That according to the best judgment of her attending physician she is pregnant.
>
> (2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history and physical examination and appropriate laboratory tests.
>
> (3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain,

perception or response, brain and heart function, the presence of internal organs and the presence of external members.

(4) That her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

(5) That abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

(6) That numerous public and private agencies and services are available to provide her with birth control information and that her physician will provide her with a list of such agencies and the services available if she so requests.

(7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(C) At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall, at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, of the par-

ticular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

(D) The attending physician performing or inducing the abortion shall provide the pregnant woman, or one of her parents or legal guardian signing the consent form where applicable, with a duplicate copy of the consent form signed by her parents or her legal guardian where applicable, in accordance with Paragraph (B) of this Section.

INTRODUCTION AND SUMMARY OF ARGUMENT

Although many of the questions presented by this case are of substantial interest to the APA, this *amicus* brief will address only the issues raised by questions (3) and (4) in the petition for *certiorari*.[1] Those questions, which deal with what must be said, and by whom, in the context of pre-abortion counseling, are of particular interest to psychologists because counseling is an integral component of the functions psychologists are trained to perform, and is one of the four recognized specialty areas of professional psychology.[2]

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[1] "(3) Can state require physician personally to inform woman of facts relating to her pregnancy, abortion procedure, fetal development, and agencies available to assist her? (4) Can state require physician personally to counsel patient with respect to risks and technique of abortion prior to performing abortion?" 50 U.S.L.W. 3429 (Nov. 24, 1981).

[2] The four areas are clinical psychology, counseling psychology, industrial/organizational psychology, and school psychology.

The APA wholeheartedly agrees that no abortion should be performed without the informed consent of the pregnant woman, and strongly endorses pre-abortion counseling to ensure that consent is informed, and to ensure that a trained professional will be available to discuss any psychological or related problems the woman might have.

To that extent, the APA supports the counseling and informed consent objectives embodied in Akron Ordinance § 1870.06(A). Our concern is not with those objectives, but with the rigid and counter-productive means the Akron City Council has chosen to achieve them. In our view, requiring clinics to provide the same blanket information to every pregnant woman, rather than to provide for each woman whatever information is individually appropriate to her particular needs, is inconsistent with basic principles of effective counseling and will hinder, rather than promote, informed consent. Similarly, requiring that the necessary information be conveyed by the "attending physician," rather than by an individual trained to perform counseling functions, even if the physician has no knowledge or experience in counseling principles and techniques, will hinder, rather than promote, informed consent.

The APA believes that §§ 1870.06(B) and (C) of the Akron Ordinance prevent the individualized counseling that is needed to obtain truly informed consent, interfere with professional judgment, and unduly burden a pregnant woman's constitutional right to make decisions concerning her pregnancy.

ARGUMENT

I. EFFECTIVE COUNSELING IS A SKILL WHICH REQUIRES SPECIALIZED KNOWLEDGE AND EXPERIENCE AND ADHERENCE TO RECOGNIZED PRINCIPLES AND TECHNIQUES, INCLUDING RESPECT FOR THE WIDELY VARYING NEEDS OF INDIVIDUAL CLIENTS.

A. Counseling Is A Recognized Professional Discipline.

The Akron City Council apparently assumed that counseling is something which anyone, or at least any "attending physician," can do. But that is not so. Although most professional psychologists who provide services to clients are trained in counseling techniques, counseling is a sufficiently complex subarea of psychology that it has been formally established by the APA as one of the four recognized specialty areas of professional psychology. The APA has adopted *Specialty Guidelines for the Delivery of Services By Counseling Psychologists* (hereafter *"Guidelines"*)[3] which delineate the standards that must be met before a psychologist can claim to specialize in counseling psychology.

Counseling psychological services are directly relevant to the decisions women, including minor women, must make in the abortion context because they "are intended to help persons . . . develop a variety of problem-solving and decision-making capabilities," and are used by persons "of all age groups." *Guidelines*, Definitions, B.[4]

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[3] 36 AMERICAN PSYCHOLOGIST 652 (1981).

[4] "Counseling psychological services refers to services provided by counseling psychologists that apply principles, methods, and procedures for facilitating effective functioning during the life-span developmental process. In providing such services, counseling psychologists approach practice with a significant emphasis on positive aspects of growth and adjustment and with a developmental orientation. These services are intended to help persons acquire or alter personal-social skills, *improve adaptability to changing life demands*,

Guideline 1.5 requires counseling psychologists to "maintain current knowledge of scientific and professional developments to preserve and enhance their professional competence." That is not an easy task because the literature relevant to the field of counseling is large and growing.[5]

B. To Be Effective, Abortion Counseling Must Be Individually Tailored To Each Woman's Particular Needs.

Guideline 2.2.3 requires counseling psychologists to adhere to the APA's *Ethical Principles of Psychologists.*[6] A central principle of the Ethical Principles is that psychologists treat people as individuals, with full respect for their individual differences: "Psychologists recognize differences among people, such as those that may be associated with age, sex, socioeconomic, and ethnic back-

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enhance environmental coping skills, and *develop a variety of problem-solving and decision-making capabilities.* Counseling psychological services are used by individuals, couples, and families of all age groups to cope with problems connected with education, career choice, work, *sex, marriage, family,* other social relations, health, aging, and handicaps of a social or physical nature." *Guidelines,* Definitions, B. (emphasis added).

Other guidelines require counseling psychologists to know about and assist their clients in using relevant human services in their communities, including "health resources" and "family-service" agencies (Guideline 2.2.5); to maintain cooperative relationships with "professionals in other fields" (Guideline 2.2.6); and to make "their services readily accessible to users in a manner that facilitates the users' freedom of choice" (Guideline 3.1, Interpretation).

[5] The APA publishes a bimonthly JOURNAL OF COUNSELING PSYCHOLOGY which covers theory, research and practice concerning counseling, emphasizing the results of empirical studies about counseling processes and interventions. Other counseling-related journals include THE COUNSELING PSYCHOLOGIST, THE JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY, PROFESSIONAL PSYCHOLOGY, PERSONNEL & GUIDANCE JOURNAL, JOURNAL OF COLLEGE STUDENT PERSONNEL, and VOCATIONAL GUIDANCE QUARTERLY.

[6] 36 AMERICAN PSYCHOLOGIST 633 (1981).

grounds." *Ethical Principles*, 2d. The importance of respect for "individual differences" is also reflected in the APA's Criteria for Accreditation of Doctoral Training Programs and Internships in Professional Psychology.[7]

Empirical studies have shown that women find pre-abortion counseling to be quite helpful to them. One study, for example, reported that 86% of the women studied "felt that the counseling was helpful to them." [8]

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[7] II. *Cultural and Individual Differences*

As a science and profession, psychology deals with the full range of human variability. It follows that social responsibility and respect for cultural and individual differences are attitudes which must be imparted to students and trainees and be reflected in all phases of the program's operation: faculty recruitment and promotion, student recruitment and evaluation, curriculum, and field training. Social and personal diversity of faculty and students is an essential goal if the trainees are to function optimally within our pluralistic society. Programs must develop knowledge and skills in their students relevant to human diversity such as people with handicapping conditions; or differing ages, genders, ethnic and racial backgrounds, religions, and life-styles; and from differing social and individual backgrounds. These principles are embodied and elaborated in the specific guidelines and criteria that follow . . . APA COMMITTEE ON ACCREDITATION, ACCREDITATION HANDBOOK (1980).

Other organizations have published standards governing counseling, including counseling in the abortion context. *See, e.g.*, PLANNED PARENTHOOD FEDERATION OF AMERICA, MANUAL OF MEDICAL STANDARDS AND GUIDELINES: PREGNANCY AND ABORTION COUNSELING 21-23 (1977); and American Public Health Association, *Recommended Program Guide for Abortion Services*, 70 J. OF THE AMERICAN PUBLIC HEALTH ASSOCIATION 652 (1980).

[8] Smith, *A Follow-Up Study of Women Who Request Abortion*, 43 AMERICAN J. OF ORTHOPSYCHIATRY 574, 583 (1973):

> The women frequently expressed appreciation for the help they had received from PCS prior to abortion. Eighty-six percent of the women felt that the counseling was helpful to them. Most frequently mentioned were the emotional support provided by the counselor and the information given regarding the abortion procedure. Only seven percent of the women did not feel that counseling was helpful to them.

But some women found counseling much more helpful than did others: "Those who found counseling least helpful were married or older single women who felt they had adequate information and were receiving emotional support from husband or friends. Younger women and those who had not confided in anyone regarding the pregnancy found the counseling of most value." [9]

Age is only one of the important variables that must be considered if the counseling is to be effective.[10] Another very important variable is the duration of the pregnancy. "It is also important to differentiate responses to first- and second- trimester abortions. Research has shown that women undergoing second-trimester abortions have more negative reactions than those having abortions

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[9] *Id.*

[10] *See, e.g.*, Adler, *Sex Roles and Unwanted Pregnancy in Adolescent Adult Women*, 12 PROFESSIONAL PSYCHOLOGY 56 (1981):

> A number of correlates of responses to abortion have been found. On the average, younger women, single women, and Catholic women react more negatively (Adler, 1975; Osofsky & Osofsky, 1972; Payne, Kravitz, Notman, & Anderson, 1976). Women with a history of previous psychiatric problems are at relatively greater risk of developing postabortion problems (Ewing & Rouse, 1973). Also at risk are women who feel coerced into terminating their pregnancy either from pressure from parents or partner or because of medical problems (e.g., Simon, Senturia, & Rothman, 1967). In one of the new longitudinal studies, Payne et al. (1976) identified seven factors that predicted difficulty in working through conflicts associated with abortion: (a) prior history of mental illness; (b) immature interpersonal relationships; (c) unstable. conflicted relationship with one's partner; (d) history of negative relationship with one's mother; (e) ambivalence regarding abortion; (f) a religious or cultural background hostile to abortion; and (g) single status, especially if one has not borne children.

Although post-abortion problems can occur, particularly if the counseling is inadequate, the overwhelming majority of women do not experience such problems. *See* TAN [text and note] n.28, *infra*.

at earlier stages of pregnancy." [11] These and other studies confirm the obvious but critically important fact that pregnant women approach the possibility of abortion with widely varying backgrounds, attitudes, levels of knowledge and familial and social support systems. To be effective and to ensure "informed" consent, the *content* of the counseling must be tailored to those individual differences and needs, and the individual providing counseling must be able to recognize those differences and the modifications of content they require.

Other studies show that the *form* of the counseling is also quite important, and that counselors must have the knowledge and freedom to modify counseling techniques, where appropriate. For example, one study found "an interaction of treatment with age. Younger women reacted better to the abortion after receiving group rather than individual counseling. Older women showed more favorable responses to abortion when counseled individually." [12]

In short, counseling is a complex process. It is a recognized professional speciality which requires specialized

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[11] Adler, *Psychosocial Issues of Therapeutic Abortion, in* D. TOURQS, (ed.), PSYCHOSOMATIC OBSTETRICS AND GYNECOLOGY 165 1980). *See, to the same effect,* Kahn-Edrington, *Abortion Counseling,* 8 THE COUNSELING PSYCHOLOGIST 37, 38 (1979).

[12] Adler, *Abortion: A Social-Psychological Perspective,* 35 J. OF SOCIAL ISSUES 100, 102 (1979). Similar results have been found with respect to men. Gordon, *Efficacy of a Group Crisis-Counseling Program for Men Who Accompany Women Seeking Abortions,* 6 AMERICAN J. OF COMMUNITY PSYCHOLOGY 239, 245 (1978): "In the present study the results indicate that a short 2-hour group-counseling session is an effective means of helping the men who accompany women seeking legal abortions to deal with their own personal crises . . . . A secondary finding shows that the counseling sessions are more effective in A-State reductions for the younger counselees. It seems that more efficacious means of helping the older men, such as individual counseling sessions, a more detailed information sheet concerning abortion, or a video tape of the clinic and its procedures, might be explored."

knowledge and techniques, and the freedom to apply that knowledge and those techniques in the manner best suited to the individual characteristics and needs of individual clients. It has been shown that, if done properly, counseling can produce positive results: "Some physicians have said that when they are performing abortions they can often tell who has received counseling and who has not. This is reflected in how tense or relaxed the woman is. Tension, in turn, affects the difficulty of performing the abortion and the degree of pain experienced." [13]

Also, counseling may be effective in encouraging women to return for post-abortion check-up: "94 of 99 women who received counseling returned to the hospital for check-up while only 60 of 99 uncounseled women did so. Return for follow-up could reduce the incidence of complications as well as provide further information about and encouragement for contraceptive use." [14]

On the other hand, it has been noted that communication of negative attitudes by hospital personnel can contribute directly to the incidence of post-abortion guilt, remorse and depression.[15]

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[13] Adler, *supra* n.12 at 108. *See also, id.* at 107: ". . . a woman's reaction to abortion may be influenced by whether or not she receives counseling and by the type of counseling she receives."

[14] Adler, *supra* n.12, at 108-109.

[15] Marder, *Psychiatric Experiences With a Liberalized Therapeutic Abortion Law*, 126 AMERICAN J. OF PSYCHIATRY 1230 (1970). *See also*, Notman & Nadelson, *Reproductive Crises*, in A. BRODSKY & R. HARE-MUSTIN, (eds.), WOMEN IN PSYCHOTHERAPY 313 (1980) *citing* Marder, *supra*. For other studies of the effects of abortion counseling, *see* Rutledge, *The Effect of Counseling on University Women Requesting Abortion*, DISSERTATION ABSTRACTS INTERNATIONAL 3383A (Univ. Microfilms No. 07435) (1978); Kay, *An Evaluation of the Long Range Aspects of Abortion Services in Chicago, Illinois: An Interdisciplinary Approach*, DISSERTATION ABSTRACTS INTERNATIONAL 4807A (1976) (Univ. Microfilms No. 75-29, 673); Dauber, Zalar & Goldstein, *Abortion Counseling and Behavioral Change*, 4 FAMILY PLANNING PERSPECTIVES 23-27 (1972);

C. The Trial Testimony Acknowledged That Physicians Often Lack the Knowledge and Skills Needed For Effective Abortion Counseling.

The testimony in the District Court confirmed two points: (1) effective abortion counseling requires specialized knowledge and skills which must be tailored to the differing needs of individual women; and (2) "attending physicians" often do not possess that knowledge and those skills.

Adele Hofmann, M.D., Director of the Adolescent Medical Unit at New York University, for example, testified that "counselors should be trained and have a body of knowledge and set of skills, but that the specific discipline by which they come [to] that or through that is not as important as their ability to relate to teenagers." [16] She did not think having an M.D. degree should be a prerequisite for abortion counselors, because the "practical point is that few physicians are trained, and many other people are better trained." [17] She stressed that generalized rules for abortion counseling are inadequate because counseling "is so individualized." [18] And she concluded that "to be honest with you, I think that probably the physician, in his preoccupation with organic needs, is

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and *see* Scott, *Possible Guidelines for Problem Pregnancy Counseling*, 23 PASTORAL PSYCHOLOGY 41-49 (1972); Joffe, *What Abortion Counselors Want From Their Clients*, 26 SOCIAL PROBLEMS 112 (1978); Potts, *Counseling Women With Unwanted Pregnancies*, in F. HASELKORN, (ed.), FAMILY PLANNING 267-280 (1971).

[16] *Transcript* (Vol. III), at 152. Dr. Hofman has had "considerable experience in training people for counseling," *id.* at 130, and has "written a number of books and a number of articles in the area of adolescent health care, adolescent sexuality, in counseling adolescents, and a variety of aspects of that sort." *Id.* at 103. Citations are to the transcript because the parties are using the deferred joint appendix authorized by Rule 30(4) of the Rules of this Court.

[17] *Id.* at 154.

[18] *Id.* at 147.

probably the least well equipped of professional and paraprofessional persons to deal with counseling effectively." [19]

Felix P. Heald, M.D., Professor of Pediatrics and Director of the Division of Adolescent Medicine at the University of Maryland, agreed, particularly when minors are involved, that abortion counselors should have "thorough knowledge of the psychological and the biological characteristics of the adolescent, and thorough knowledge of the counseling." [20] He also concluded that "some counselors are much better counselors than physicians," and that "some nonphysicians are much better than physicians in gathering information from teenagers." [21]

Jay Katz, a physician on the faculty of the Yale Law School and one of the foremost authorities on informed consent, agreed that "doctors, both by the nature of their training and by the nature of the economic pressures and time pressures that they are under, generally do not take the time to inform, and what seems to be evolving—it surely has evolved in our community that physicians and surgeons employ paramedical personnel to do a great deal of the preliminary informing process." [22]

Amicus is not suggesting that physicians can never provide effective abortion counseling. If they have received appropriate training, physicians can make excellent counselors, as can psychologists, nurses, social workers, and others. But effective counseling does require specialized training, and *ordinarily*, physicians have not received that training. Unlike physicians, who rarely

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[19] *Id.* at 131. Dr. Hofmann also noted that physicians are often under pressure to work fast and see many patients, which decreases their ability to be effective counselors. *Id.* at 153.

[20] *Transcript* (Vol. II), at 109. See to the same effect, *id.* at 90. Dr. Heald "was trained in counseling earlier in [his] career." *Id.* at 115.

[21] *Id.* at 109.

[22] *Transcript* (Vol. IV), at 130-131.

receive such training, most doctoral level professional psychologists have received intensive training in interpersonal dynamics and counseling techniques, and most of them would be qualified to provide effective abortion counseling.

II. SECTIONS 1870.06(B) AND (C) OF THE AKRON ORDINANCE PREVENT EFFECTIVE COUNSELING, INTERFERE WITH PROFESSIONAL JUDGMENT, AND UNDULY BURDEN A WOMAN'S CONSTITUTIONAL RIGHT TO MAKE DECISIONS CONCERNING HER PREGNANCY.

As *amicus* showed in Point I, effective counseling requires special training and skills, but the Akron Ordinance does not allow physicians the discretion to delegate the sensitive task of counseling to those who are better qualified to provide it. The Ordinance also deprives physicians of discretion to decide what to discuss with their patients. As we will now show, by limiting professional discretion in these two ways, the Ordinance unduly burdens the woman's constitutional right to make decisions concerning her pregnancy.

Section 1870.06(B) and (C) violate the cardinal principle of effective counseling. Instead of tailoring the information communicated to each woman to meet her particular needs, those sections require that the *same* information be given to *all* women, regardless their individual wishes or needs. A forty year old lawyer and mother of three children who has decided, in agreement with her husband and family physician, to terminate her pregnancy early in the first trimester, and who has no ambivalence about that decision, must be given the same rote information as an unmarried fourteen year old high-school drop-out living at home who has reluctantly decided late in the second trimester to accede to pressures from her parents to have an abortion, despite her desire, and

the demand of her boyfriend, that she continue her pregnancy to term.

It is no answer to suggest, as does petitioner (Pet. Br. at 33 and 36), that after giving the required informaton the counselor could perhaps go on to provide more individualized information, because individualized counseling requires professional discretion not only regarding what *to* say, but also regarding what *not* to say. Giving much of the information specified in the Akron Ordinance would actually harm certain clients, and might undermine the trust and confidence that are essential to effective counseling. For example, it could certainly be harmful to a woman impregnated during a violent rape to be told in detail the anatomical characteristics of her fetus, if every reference to the fetus vividly recalls the horror of her experience. If she asks her counselor to avoid that subject, but the counselor nevertheless persists, as the Akron Ordinance requires, it is unlikely that at the end of that recitation the counselor will have earned the trust needed to engage in more individualized counseling. The harm will have been done, and the possibility of useful and effective counseling will have been destroyed.

There was no dispute at trial that communicating certain kinds of information to certain kinds of clients can cause substantial harm, and can impair an effective counseling relationship. Testifying generally about situations in which giving certain kinds of information would actually pose a "health risk," Jay Katz, M.D., referred to

> . . . studies that seem to indicate that about anywhere from 11 to 17 percent in reported studies of patients do not wish to know a great deal about what is in store for them, and they feel even angry and psychologically traumatized if they are informed and surely, in such situations as acute distress, like myocardial—like heart attacks, when it is important for the patient to be as tranquil as possible to have an extended discussion about consent to various med-

ical interventions could be detrimental to the patient's welfare.[23]

Dr. Katz then testified that giving *all* patients the same, detailed information required by section 1870.06 (B)(3) would "have a detrimental impact on the informed consent process for a number of reasons."[24] One reason was that failure to respect individual differences and needs could actually result in permanent harm for some women:

> Then, what is also wrong with this section is that it is a requirement for all patients, irrespective of the situation where it is clear to the patient and physician alike that she wants the procedure performed, and the procedure is professionally indicated, and then to burden the patient with this additional detailed information could be frightening. It could, in a sense, leave permanent traumatic memory traces for the rest of her life to know in detail what the doctor imagines the fetus looks like at that particular moment in time, particularly since it is so hard to communicate the things required in the statute effectively and sensitively.[25]

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[23] *Id.* at 106-107.

[24] *Id.* at 111.

[25] *Id.* at 112-113. It is hard to communicate that information effectively and sensitively because complying with the ordinance:

> . . . would require the doctor to practically disclose a great deal about all that is known about embryology anatomy to the patient. The fetus develops very rapidly in the early months of gestation, and since one can never be absolutely sure within days as to what the developmental stage of the fetus is, so much would have to be told about tactile sensitivity, limb development, heart function, et cetera, that an information overload would be presented to the patient, and from psychology, we know that when too much information is presented, the person just cannot digest it.

Id. at 111-112.

Dr. Felix P. Heald agreed, and testified that the information contained in section 1870.06(B)(3) ". . . would be a punitive and cruel statement to read to a teenager . . . . I think it is a harsh statement that serves no particular end, other than a negative one . . . . Again, I think it is because of characteristics of the adolescent, the emotional, the developmental characteristics; particularly for the younger teenager. This would be inappropriate, highly inappropriate." [26]

Even the expert witnesses called by defendants agreed that there are circumstances in which automatically giving all of the information specified in the Akron Ordinance could harm individual women.[27] And yet, that is what the ordinance mandates.

The problem is compounded because much of the information which the ordinance requires to be given is inaccurate or seriously misleading. The respondents will address this point more fully. *Amicus* simply wishes to note, in passing, the claim in § 1870.06(b)(5) "that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances." This statement is seriously misleading because a great many empirical studies have shown that abortion rarely causes or exacerbates psychological or emotional problems. To

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[26] *Transcript* (Vol. II), at 88. Dr. Heald expressed similar reservations about §§ 1870.06(B)(4) and 1870.06(B)(5). *Id.* at 88, 89. *See also* the counseling guidelines published by the American Public Health Association, *supra* n.7: "Counseling should not be done in such a way as to increase the patient's anxiety by requiring vivid descriptions or pictures of fetal development . . . . The information must not include inaccurate statements." 70 J. OF THE AMERICAN PUBLIC HEALTH ASSOCIATION 652, 654 (1980).

[27] *E.g.*, Seguin, *Transcript* (Vol. VII), at 87-88; Sim, *Transcript* (Vol. VII), at 83-84; Wilkie, *Transcript* (Vol. IX), at 66; Schmidt, *Transcript* (Vol. X), at 53.

the contrary, the great majority of women who have had an abortion express feelings of relief.[28]

More individualized counseling tacked on at the end of this recitation of potential problems will not eliminate the unnecessary anxiety that is created thereby. If the counselor says "I am required by law to tell you that abortion is a major surgical procedure, which can result in serious complications," and then recites the required list of complications, will the anxiety that such a recitation creates disappear if the counselor then adds, "but don't worry, it's not really a major procedure and I don't think those things will happen to you"? That kind of "more individualized" counseling forces the woman, already in an anxiety provoking situation, to weigh the credibility of her elected representatives against the credibility of a counselor she may never have met before.

In light of the foregoing, if they were free to exercise professional judgment and discretion, many physicians would choose, in individual cases, not to communicate much of the information contained in § 1870.06(B). Similarly, if they were free to exercise professional judgment and discretion, many physicians, particularly those who have little or no knowledge of

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[28] *E.g.*, Peck & Marcus, *Psychiatric Sequelae of Therapeutic Interruption of Pregnancy*, 143 J. OF NERVOUS AND MENTAL DISEASE 417 (1966); Patt, Rappaport, & Barglow, *Follow-up of Therapeutic Interruption of Pregnancy*, 20 ARCHIVES OF GENERAL PSYCHIATRY 408 (1969); Senay, *Therapeutic Abortion: Clinical Aspects*, 23 ARCHIVES OF GENERAL PSYCHIATRY 408 (1970); Whittington, *Evaluation of Therapeutic Abortion as an Element of Preventive Psychiatry*, 126 AMERICAN J. OF PSYCHIATRY 1224 (1970); Brody, Meikle & Gerritse, *Therapeutic Abortion: A Prospective Study*, 109 AMERICAN J. OF OBSTETRICS AND GYNECOLOGY 347 (1971); Osofsky & Osofsky, *The Psychological Reaction of Patients to Legalized Abortion*, 42 AMERICAN J. OF ORTHOPSYCHIATRY 574 (1973); Simon, Senturia & Rothman, *Psychiatric Illness Following Therapeutic Abortion*, 124 AMERICAN JOURNAL OF PSYCHIATRY 97 (1967); Niswander & Patterson, *Psychological Reaction to Therapeutic Abortion*, 29 OBSTETRICS AND GYNECOLOGY 702 (1967).

counseling themselves, would decide that it would be in the best interests of their patients for them to receive counseling from a third party trained in counseling techniques. *See* Point I(C), *supra*. But the Akron Ordinance denies physicians the freedom to exercise that professional judgment.

In many different contexts, this Court has stressed the deference that should be shown to judgments made by qualified professionals. The most recent example is *Youngberg v. Romeo*, —— U.S. ——, 102 S.Ct. 2452 (1982).[29] It is particularly important that professional judgment be unfettered in the abortion context, because in that context the woman necessarily relies on professional judgment in making decisions she has a *constitutional* right to make. Since, in the abortion context, professional judgment is inextricably related to exercise of a constitutional right, legislation which burdens exercise of professional judgment burdens exercise of that constitutional right.

It should not be surprising, therefore, that this Court has repeatedly stressed the importance of professional judgment in the abortion context. Beginning with *Roe v. Wade*, 410 U.S. 113, 165-166 (1972), the Court noted that its decision:

> . . . vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.

Even after viability, when the state could otherwise prohibit abortion entirely, the Court made an exception where abortion "is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 410 U.S. at 165.

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[29] *See also, Parham v. J.R.*, 442 U.S. 584, 607-608 (1979); and *Bell v. Wolfish*, 441 U.S. 520, 544 (1979).

In *Doe v. Bolton*, 410 U.S. 179 (1973), the Court again stressed the importance of giving the physician "the room he needs" to exercise professional judgment.[30]

In *Planned Parenthood Federation of Central Missouri v. Danforth*, 428 U.S. 52, 80 (1976), the Court warned against "restrictions or regulations governing the medical judgment of the pregnant woman's attending physician with respect to the termination of her pregnancy." The Court expressly ruled that "it is not the proper function of the legislature" to define the point at which the fetus becomes viable because that "essentially is a medical concept." *Id.* at 64. As the Court explained: "The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician." *Id.* And in accepting as the meaning of "informed consent" the "giving of information to the patient as to just what would be done and as to its consequences," the Court observed that to "ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Id.* at 67 n.8.

In *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977), the Court cautioned against "placing obstacles in the path of

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[30] The net result of the District Court's decision is that the abortion determination, so far as the physician is concerned, is made in the exercise of his professional, that is, 'best clinical,' judgment in the light of *all* the attendant circumstances. He is not now restricted to the three situations originally specified. Instead, he may range farther afield wherever his medical judgment, properly and professionally exercised, so dictates and directs him . . . . the medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. 410 U.S. at 191, 192 (emphasis in original).

the doctor upon whom she was entitled to rely for advice in connection with her decision." And in *Colautti v. Franklin*, 439 U.S. 379, 387 (1979), the Court canvassed its earlier decisions and stressed once again the "importance of affording the physician adequate discretion in the exercise of his medical judgment."

The Akron Ordinance directly and substantially burdens the exercise of professional judgment and it therefore burdens exercise of the woman's constitutional right. The only remaining question is whether the burden is an "undue" burden. Since there are alternatives that would achieve all of Akron's legitimate objectives, without burdening professional judgment, it is clear that the burden created by the ordinance is unnecessary and undue. For example, Akron could require the physician or other counselor to convey specified information unless, in the counselor's judgment, communicating some or all of the specified information would be inappropriate for a particular woman.[31] Similarly, Akron could establish minimum standards that all abortion counselors, whether physicians or non-physicians, would have to meet. In either event, to ensure a meaningful relationship between the woman and the attending physician, Akron could require the attending physician, in every case, to ask the woman if she feels adequately informed, and to offer to answer or obtain the answer to any remaining questions she might have. In these and other ways, Akron could achieve its entirely legitimate objective of ensuring that each woman will be in a position to give informed consent, without interfering with professional judgment or unduly burdening exercise of the woman's constitutional right to make decisions concerning her pregnancy.

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[31] Of course, although the counselor should have broad latitude in exercising professional judgment, he or she must always communicate sufficient information to permit informed consent, as required by the constitution and ethical principles.

CONCLUSION

The Judgment of the Sixth Circuit Court of Appeals Finding Akron Ordinance Sections 1870.06(B) and (C) Unconstitutional Should Be Affirmed

Respectfully submitted,

BRUCE J. ENNIS, JR.
(Counsel of Record)
DONALD N. BERSOFF
ENNIS, FRIEDMAN, BERSOFF & EWING
1200 Seventeenth Street, N.W.
Washington, D.C. 20036
(202) 775-8100
Attorneys for Amicus Curiae
American Psychological Association

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
Appellee.

CITY OF AKRON, *et al.*,
Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Petitioners,

—v.—

CITY OF AKRON, *et al.*,
Respondents.

MOTION FOR LEAVE TO FILE AND BRIEF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, *AMICUS CURIAE*

DAVID B. HOPKINS
PATRICIA E. HENNESSEY
Civil Liberties and Public Policy Program
Hampshire College
Amherst, Massachusetts 01002

Attorneys for Amicus Curiae

MOTION FOR LEAVE TO FILE

The American Public Health Association (APHA) hereby respectfully moves for leave to file the attached brief amicus curiae. Consent for the filing of this brief was obtained from the attorneys for Dr. Chris Simopoulos, the Akron Center for Reproductive Health, Inc., the City of Akron and Respondents Seguin and Black. The consent of the attorneys for the State of Virginia was requested but refused.

APHA is a national, nongovernmental organization established in 1872 with the objective of protecting and promoting personal and environmental health. APHA is the largest public health organization in the world, with a membership of

50,000, including fifty-one state and local affiliate organizations.

APHA was the first organization of health professionals in this country to recognize the detrimental consequences of illegality and inaccessibility of abortion to women. Prior to this Court's landmark rulings in 1973, and as early as 1968, APHA supported the principle that abortion should be a matter of choice for all women. Following the decisions of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) APHA urged their full implementation in every state in order to make abortion a matter of safe medical practice throughout the nation.

APHA has appeared as amicus in many other important health-related cases before this Court, including

Roe v. Wade, supra, Beal v. Doe, 432 U.S. 464 (1977) and Collautti v. Franklin, 439 U.S. 379 (1979). This Court extensively quoted APHA's "Standards for Abortion Services" in Roe v. Wade, 410 U.S. at 144-46. APHA has also appeared as amicus in numerous cases in federal and state courts, including at the District and Circuit Courts in Akron Center for Reproductive Health Care, Inc. v. City of Akron.

APHA's objective in the abortion field is to assure that safe abortion services are in fact readily accessible to all women, regardless of socio-economic status. It is APHA's position that second trimester abortions may be safely performed in qualified, non-hospital facilities. Based on that policy, and the medical

research which supports it, APHA believes that requirements of hospitalization for all second trimester abortions are not justifiable as necessary to preserve maternal health.

Because these cases raise important questions concerning state regulation of abortion services, amicus respectfully urges this Court to accept and file the enclosed brief amicus curiae.

Respectfully submitted,

David B. Hopkins
Patricia E. Hennessey
Civil Liberties and
Public Policy Program
Hampshire College
Amherst, Massachusetts
10102

Attorneys for
Amicus Curiae

TABLE OF CONTENTS

	Page
MOTION FOR LEAVE TO FILE	i
TABLE OF AUTHORITIES	vii
INTEREST OF AMICUS	1
SUMMARY OF ARGUMENT	2
ARGUMENT	
I. STATE STATUTES AND LOCAL ORDINANCES WHICH REQUIRE ALL SECOND TRIMESTER ABORTIONS TO BE PERFORMED IN HOSPITALS SEVERELY RESTRICT ACCESS TO ABORTION SERVICES AND MAY ENDANGER WOMEN'S HEALTH.	4
A. There is A Large Unmet Need for Second Trimester Abortion Services. Hospitalization Requirements Exacerbate that Need.	4
B. The Cost of In-Hospital Second Trimester Procedures Far Exceeds That of Non-Hospital Services.	10
C. Hospitalization Requirements Result in Delay in Obtaining Abortions Services Which Has a Proven Negative Effect on Health.	11

D. Hospitalization Requirements Pose Particular Problems for Pregnant Teenagers. 13

E. Recent Evidence From Medical Association Finds Hospitalization Requirements Are Not Justifiable As Necessary for the Preservation of Maternal Health. 25

II. THE COURT MUST EXAMINE THESE REGULATIONS WITH STRICT SCRUTINY BECAUSE THEY IMPOSE A RESTRICTION ON A FUNDAMENTAL RIGHT. 31

III. THE STATUTE AND ORDINANCE SINGLE OUT ABORTION FOR DIFFERENT TREATMENT IN MEDICAL REGULATION. 36

IV. CONCLUSION 39

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INTEREST OF AMICUS

The interest of amicus is set forth substantially in the foregoing motion. Amicus respectfully informs the Court that it is in full agreement with the discussion of issues contained in the brief filed by Planned Parenthood Federation of America in Akron Center for Reproductive Health Inc. v. City of Akron and Planned Parenthood of Kansas City Inc. v. Ashcroft. APHA has particular expertise and interest in the need for, cost of, and availability of heath care services, including abortion. Therefore, amicus submits this brief limited to the issue of second trimester hospitalization requirements and their effect on access to needed abortion services.

SUMMARY OF ARGUMENT

Abortion services are not available to every woman who needs them. Hospitals contribute to this unmet need by failing to offer abortion services, particularly second trimester abortions. Hospitalization requirements impose a burden on reproductive choice by restricting access to abortion and by making second trimester abortions more difficult and more costly to obtain. Teenagers suffer most from hospitalization requirements. Mature minors may effectively be denied the right, established by this court, to obtain a second trimester abortion without parental consent. Point IA-D.

Since 1973 medical knowledge and practice, evidenced by the policies and standards of the American Public Health Association and The American College of

Obstetricians and Gynecologists, has advanced to the point where second trimester abortions can be performed safely in clinics, with less delay and cost than in hospitals. Point IE.

Under previous rulings of this court including Roe v. Wade, 410 U.S. 113 (1973) Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) and Carey v. Population Services International, 431 U.S. 678 (1979) restrictions on abortion warrant strict judicial scrutiny. Point II.

ARGUMENT

I. STATE STATUTES AND LOCAL ORDINANCES WHICH REQUIRE ALL SECOND TRIMESTER ABORTIONS TO BE PERFORMED IN HOSPITALS SEVERELY RESTRICT ACCESS TO ABORTIONS SERVICES AND MAY ENDANGER WOMEN'S HEALTH.

A. There Is A Large Unmet Need For Second Trimester Abortion Services. Hospitalization Requirements Exacerbate That Need.

After this Court's decision of Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973), abortion became a legal medical procedure throughout the country. However, today, close to a decade after the decisions, abortion services are not available to every woman who needs them. The biggest area of unmet need is second trimester services. Hospitalization rquirements like those of Virginia and Akron, Ohio reduce the amount of second trimester services available to women.

Hospitals have not responded to this Court's decisions of Roe and Doe by integrat-

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ing abortion into their programs of health care services. In 1978 only 29% of all short-term, general, non-Catholic hospitals performed any abortions at all. Only 20% of those hospitals performed more than 30 procedures per year. Alan Guttmacher Institute, Abortion Needs and Services 1977-79 at 36 (1981) [Hereinafter cited as AGI Abortion Needs. Most Abortions are performed in specialized, non-hospital facilities known as "free standing clinics." In 1978 there were approximately 533 such clinics in the United States. F. Jaffe, B. Lindheim and P. Lee, Abortion Politics 35 (1981) [Hereinafter cited as Jaffe, Abortion Politics] However, hospitals are not abdicating abortion services in favor of these clinics. Most of the 1,728 public and 2,185 private hospitals which provided no abortion services in 1978 were located in non-metropolitan areas where there were no other abortion facilities available. AGI, Abortion Needs at 36.

Even fewer perform second trimester procedures and the number is declining.[1] In 1978 only 39% of the hospitals which provided any abortion services performed second trimester procedures. In that year only 635 hospitals performed second trimester procedures, 90 fewer than the estimated number in 1977. AGI, Abortion Needs at 58. In contrast, where not precluded by law, the number of free standing clinics that perform second trimester abortion services is increasing. Id.

The two states represented in the cases at bar provide graphic examples of the unmet need for second trimester services. As the Sixth Circuit found, in Akron, Ohio in 1977, only two hospitals performed any second trimester abortions, and in those two hospitals only nine second trimester procedures were

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[1] The vast majority of all abortions are performed in the first trimester of pregnancy. In 1978 only 9% of all abortions were performed more than 12 weeks after the onset of the last menstrual period. AGI, Abortion Needs at 13.

performed in the entire year. The estimated need for second trimester abortions in Akron was approximately 600 (10% of the 6000 women who sought abortions at Akron clinics.) Akron Center for Reproductive Health Inc. v. City of Akron, 651 F.2d 1198, 1209 (6th Cir. 1981) Similarly, in northern Virginia, the site of Dr. Simopoulos' practice, only two hospitals perform any second trimester abortions. Commonwealth v. Simopoulos, 221 Va. 1059 277 S.E. 2d 194, 204 (Va. 1981). Clearly, hospitals are not meeting the existing need for second trimester abortion services. Statutes and ordinances which limit the performance of second trimester abortions to hospitals will exacerbate the significant problem of unmet need.

The availability of second trimester abortion was an important factor in ruling on the constitutionality of second trimester restrictions in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 78-79 (1976):

> Those unappreciated or overlooked factors [unavailability of prostaglandin method in Missouri] place the state's decision to bar the use of saline in a completely different light. The State, through §9 would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces - woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.
>
> As so viewed, particularly in the light of present unavailability - as demonstrated by the record - of the prostaglandin technique, the outright legislative proscription of saline fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting the vast majority of abortions after the first 12 weeks. As such, it does not withstand constitutional challenge.

As the Sixth Circuit recognized, when hospitals are the only source of second trimester abortion many women are unable to find services, or to pay for them, see Point I.B., infra. For these women there are three stark alternatives: carrying the

pregnancy to term, attempting self-abortions, or seeking an illegal abortion. Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209. Each of these alternatives is more dangerous to the woman's health than second trimester abortion, the latter two far more dangerous.[2]

---

[2] The experience of APHA members reveals that a significant percentage of women seeking second trimester abortions do so because of an identified threat to their lives of health such as pregnancy at a very young age or involving a fetus with known, serious congenital abnormalities or disease. Continuation of pregnancy for these women presents a heightened risk to their physical and psychological health, and the inability to obtain needed second trimester abortion services can be devastating. See, APHA Resolution 7907, "The Right to Second Trimester Abortion" (1979).

B. The Cost of In-Hospital Second Trimester Procedures Far Exceeds That of Non-Hospital Services.

The cost of abortion services in a hospital always exceeds the cost of parallel services in a clinic. In 1976 the average charge for an outpatient, first trimester abortion in a hospital was $250 plus the physician's fee. In-patient procedures were, of course, far more costly. In contrast, the average total cost of a first trimester procedure at a clinic at that time was $185-235. Jaffe, Abortion Politics at 36.

For second trimester abortion services the difference in cost is more pronounced.[3]

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[3] The Sixth Circuit noted testimony that the cost of a second trimester abortion in a hospital ($850 to 900) was more than double that of a second trimester abortion in a clinic ($350 to 400) Akron Center for Reproductive Health v. City of Akron, 651 F.2d at 1209.

C. Hospitalization Requirements Result in Delay in Obtaining Abortion Services, Which Has A Proven Negative Effect on Health.

Hospital abortions are characterized by added cost, limited geographic accessibility and added procedural complexities (e.g. scheduling the surgical facilities and the physician). These factors may delay a woman obtaining services. Delay is one of the most important factors in the risk of abortion morbidity. "Our findings clearly demonstrate that any delay increases the risk to a pregnant woman who wishes an abortion." W. Cates, K. Schulz, D. Grimes and C. Tyler, The Effect of Delay and Method Choice on the Risk of Abortion Morbidity, 9 Family Planning Perspectives 266, 268 (1977) [Hereinafter cites as Cates, et al., The Effect of Delay] (emphasis in the original). See also M. Bracken and S. Kasl, Delay in Seeking Induced Abortion:

A Review and Theoretical Analysis, 121 American Journal of Obstetrics And Gynecology 1008 (1975).

Legal abortion, including second trimester abortion is a remarkably safe procedure. See, e.g. W. Cates and D. Grimes, "Morbidity and Mortality of Abortion in the United States" in Abortion and Sterilization 155 (J. Hodgson, et. 1981) [Hereinafter cited as Cates and Grimes "Morbidity and Mortality"]. However, a decade of experience with legal abortion throughout the United States has confirmed that the earlier an abortion is performed, the less the risk of morbidity or mortality. "[D]elays of any sort--whether administrative, medical or social increase the risk of complication." Id. at 159; The Earlier the Safer Applies to All Abortions 10 Family Planning Perspectives 243 (1978); Cates, et al.,

The Effect of Delay at 267-68.

Thus, hospitalization regulations may have a significantly adverse effect on the health of even those women who are ultimately able to obtain second trimester abortions in hospitals.

D. Hospitalization Requirements Pose Particular Problems for Pregnant Teenagers.

For young women, the need for second trimester abortions is most acute, and the consequences of inaccessibility of those services is most severe.

1. Teenagers Have a Greater Need for Second Trimester Abortions.

This court has found previously that the number of teenage pregnancies have increased dramatically over the last twenty years, and that teenagers are disproportionately more likely to seek abortions. Michael M. v. Superior Court of Sonomoa

County, 450 U.S. 464, 470-71 (1981). See also, W. Cates, "Abortion for Teenagers" in Abortion and Sterilization 141 (J. Hodgson ed. 1981) [Hereinafter cited as Cates, "Abortion for Teenagers".] Teenagers are more likely than women in their 20's to need second trimester abortions. The younger the teenager, the greater incidence of second trimester abortion. "14 percent of abortions obtained by girls younger than 14 are performed at 16 weeks gestation or later, compared to just 7 percent of abortions among those aged 15-19 and 4 percent of abortion among women aged 20-24." Alan Guttmacher Institute, Teenage Pregnancy: The Problem That Hasn't Gone Away 55 (1981) [Hereinafter cited as AGI, Teenage Pregnancy] 52 percent of abortions obtained by girls under 14 are performed from 9 to 15 weeks gestation. Id.

The reasons teenagers often do not obtain abortions until midtrimester are varied. Lack of access to abortion services is a major cause. Id., L. Klein, Antecedents of Teenage Pregnancy 21 Clinical Obtetrics and Gynecology 1151, 1154 (1978); Cates, "Abortions for Teenagers" at 144. Another frequently cited factor in causing delay is the failure to recognize or suspect pregnancy, often due to a lack of understanding of the facts of reproduction. L. Klein, supra at 1154; Alan Guttmacher Institute, 11 Million Teenagers 30 (1976) [Hereinafter cited as AGI, 11 Million Teenagers.] For some young teenagers, irregular menstrual cycles make pregnancy detection difficult. AGI, Teenage Pregnancy at 56. In addition, many teenagers, faced with an unplanned pregnancy, and without the resources or skills of older women to cope with such a crisis,

psychologically deny the fact of pregnancy, often until anatomical changes are obvious, well into the second trimester. Cates, "Abortions for Teenagers" at 144. Given the obstacles teenagers face in pregnancy detection and obtaining abortion services, it is clear that teenagers will continue to need second trimester services:

> [T]he problem of late abortions, especially to teenagers, will not be significantly influenced by public health interventions. Thus, continued efforts are needed to make late abortion procedures safer, cheaper, more available, and more acceptable to women undergoing them.

Id. at 145

2. Hospitalization Requirements Create A Special Burden for Young Women.

The three consequences of hospitalization requirements--added cost, travel and delay--are particularly burdensome for teenagers. The methods of fundraising available to most teenagers are unlikely

to be sufficient to raise the $800 to 1,000 needed for an in-patient second trimester abortion. The lack of Medicaid funds for abortion in most states further complicates a teenager's problem. Most teenagers are dependent on their parents, partners, or public funds to pay for their abortions. See M. Hanson, Abortion in Teenagers, 21 Clinical Obstetrics and Gynecology 1175, 1179 (1978) (Young teenagers try to earn money for abortion through babysitting, resulting in delay.)

Research indicates that "the farther a woman has to travel to obtain an abortion, the less likely she is to have one." J. Shelton, E. Brann and K. Schultz, Abortion Utilization: Does Travel Distance Matter? 8 Family Planning Perspectives 260, 262 (1976). In that study, the effect of travel distance was most pronounced for black teenagers. Id. For young teenagers,

arranging travel outside one's own community is particularly difficult. The cost of travel adds further to the extremely high cost of obtaining second trimester abortions.

Since a large number of teenagers do not seek abortion services until well into the second trimester, further delay resulting from the limited availability of hospital services or hospital procedures will have the effect of advancing the abortion into a stage of significantly greater risk and for some, preclude abortion altogether.

3. The Consequences of Being Unable to Obtain a Second Trimester Abortion are Devastating to Teenagers.

Unintended pregnancy is frequently a severe physical, psychological and emotional crisis in the life of a teenager. "There are few situations in which denying a minor the right to make an

important decision will have consequences so grave and indellible." Bellotti v. Baird, 443 U.S. 622, 642 (1979). The gravity is equal when a teenager is unable, by reason of a state or local law to effectuate that decision.

For teenagers abortion, including second trimester abortion is safer than childbirth. "Teenagers have a lower death-to-case rate than older women after a legally induced abortion", even accounting for the disproportionate number of second trimester procedures obtained by teenagers. Cates, Abortions for Teenagers at 146. The risk of death from pregnancy continuation for teenagers is at least five times that of pregnancy termination. Id.

Teenagers, especially young teenagers, are at great risk in pregnancy. Fatal complications of pregnancy are 60 percent more likely for a girl under 15 than for a

woman 20-24, and 13 percent more likely between the ages of 15 and 19. AGI, 11 Million Teenagers at 23; L. Tryer, Complications of Teenage Pregnancy, 21 Clinical Obstetrics and Gynecology 1135 (1978). "Studies have shown that teenagers have a greater incidence of toxemia, abrupto placentae and cephalopelvic disproportion in pregnancy." G. Ryan and J. Schneider, Teenage Obstetric Complications, 21 Clinical Obstetrics and Gynecology 1191 (1978).[4]

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[4] Amicus does not suggest that all teenage pregnancies ought to be terminated. "Recent studies indicate that good prenatal care and attention to the psychosocial and economic problems of pregnancy reduced perinatal death and complication rates for pregnant teenagers." G. Ryan and J. Schneider, supra, at 1191. For those teenagers who wanted but could not obtain second trimester abortion services such good prenatal care and concern is not likely. In addition, the stress of the unwanted pregnancy and inability to obtain an abortion add further physical and psychological risk to the pregnancy.

(footnote continued)

4. Hospitalization Requirements May Have the Effect of Denying Minors the Right to Obtain Abortion Without Parental Consent.

In addition to the burdens on access caused by the cost, travel and delay, hospitalization requirements may pose an acute problem of constitutional dimensions for minor women--the inability to obtain an abortion without parental consent. It is not unusual for hospitals, like those of Northern Virginia, not to admit or treat minor women without parental consent.[5]

(footnote continued)

It is inevitable, therefore, that teenagers who are unable to obtain second trimester abortions will have pregnancies marked by a much heightened risk of health damage or death.

[5] Amicus does not address in this brief the validity of direct parental notice or consent statutes or provisions such as Secs. 1870.05(A) and 1870.05(B) of the "Akron Ordinance."

This court has recognized that minors as well as adults are protected by the Constitution, specifically that they enjoy a right of privacy. In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 74 (1976) this court held that a state could not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy. After the Danforth decision, this court has examined a number of statutes relating to minors and abortion. The court has held that states which seek to require parental consent for abortion "must provide an alternative procedure whereby authorization for the abortion can be obtained without first consulting a parent." Bellotti v. Baird, 443 U.S. 622, 643 (1979) Further, in such procedures if a "pregnant minor shows (1) that she is mature enough and well enough informed to make her abortion

decision in consultation with her physician independently of her parents wishes or (2) that even if she is not able to make this decision independently, that the desired abortion would be in her best interests" 443 U.S. at 643-44, the minor's choice must be effected.

In Bellotti v. Baird, 443 U.S. at 642 this court stated:

> The abortion decision differs in important ways from other decisions that may be made during minority. The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a state to act with particular sensitivity when it legislates to foster parental involvement in this matter.

Even if it would be permissible or appropriate to require parental consent for all other medical or surgical procedures in a hospital, "the unique nature and consequences of the abortion decision make it inappropriate" to allow such blanket consent

requirements. Bellotti v. Baird, 443 U.S. at 643.

This court has recognized that "many parents hold strong views on the subject of abortion and young, pregnant minors, especially those living at home, are particularly vulnerable to their parents' efforts to obstruct both an abortion and their access to court." Bellotti v. Baird, 443 U.S. at 647 Clearly the same holds true when a minor needs access to a hospital for a second trimester abortion.

By refusing to consent to hospital admission parents could exercise an absolute veto over a minor's decision to terminate a pregnancy in the second trimester. Hospitalization regulations like the ones at issue would have the effect of doing indirectly what this court has repeatedly held a state may not do

directly--require all minors to obtain parental consent prior to obtaining a second trimester abortion. Planned Parenthood of Central Missouri v. Danforth, supra; Belloti v. Baird, supra. See also H. L. v. Matheson, 450 U.S. 398 (1981).

E. Recent Evidence From Medical Associations Finds That Hospitalization Requirements Are Not Justifiable as Necessary for the Preservation of Maternal Health.

As noted by this court in Roe v. Wade, 410 U.S. at 145, in 1970, APHA's first Recommendations on Abortion Services contained a recommendation that second trimester procedures be performed in hospitals. That recommendation was based on the limited research available, which was in turn based on the limited number of legal abortions performed in the 1960's. In 1979 APHA revised its position that all second trimester abortions should

be done in hospitals on an in-patient basis. This change is reflected in the APHA Resolution 7907, "The Right to Second Trimester Abortion" (Adopted November 1979).

Recently the American College of Obstetricians and Gynecologists (ACOG) revised its 1974 Manual of Standards and approved the performance of early second trimester abortions in clinics' 1982 ACOG Manual of Standards. These policy revisions are based on research and practice subsequent to 1973, and thus were not available to either APHA or to this Court at the time Roe v. Wade, supra, and Doe v. Bolton, supra, were decided.[6]

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[6] The City of Akron has relied heavily on the 1974 ACOG standard throughout this litigation, in an attempt to satisfy its burden, as defined by this court in Planned Parenthood of Central

(footnote continued)

In Roe v. Wade, 410 U.S. at 163 this court recognized that permissible state regulation of abortion to protect maternal health must be measured "in the light of present medical knowledge." This recognition of the advancing state of medical knowledge, treatment, and practice in the field of pregnancy is critical to the consideration of challenges to second trimester hospitalization requirements.

(footnote continued)

Missouri v. Danforth, 428 U.S. 52, 77-78, n.12 (1976). That burden requires Akron as the proponent of a restriction on access to establish facts which would show that the hospitalization requirement is sufficiently related to the state's legitimate interest in women's health. Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1208 (6th Cir. 1981)

Up-to-date medical data from APHA and ACOG has informed this court's decisions in previous cases, particularly on the issues of abortion safety and the relative risks of childbirth and abortion. See Roe v. Wade, 410 U.S. at 163, Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 76-9.

While there are no published studies presently available that compare the safety of hospital and non-hospital abortions in the second trimester, the U.S. Department of Health and Human Services (formerly the Department of Health, Education and Welfare) has researched the comparative risk of death for hospital and non-hospital abortions at twelve weeks or less. This study revealed no major differences between the risks of death in the two types of institutions. D. Grimes et al., Comparative Risk of Death from Legally Induced Abortion in Hospital

and Non-Hospital Facilities, U.S. Department of Health, Education and Welfare, Center for Disease Control (1980). The results of this study have significance for midtrimester procedures in that the causes of death or complications for second trimester abortions are similar to those for first trimester abortions. If non-hospital facilities, therefore, meet adequate minimum standards[6] for dealing with the complications which may occur with second trimester abortions, there is no longer any reason to believe that the hospital setting is safer.

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[6] Amicus supports the National Abortion Federation and Planned Parenthood standards for non-hospital abortion facilities as constituting "minimum standards."

As Dr. Willard Cates, an expert on the medical consequences of abortion and childbirth, and for a number of years the head of the Abortion Surveillance Unit of the Center for Disease Control stated in connection with the formulation of APHA policy:

> I do not favor any proposed legislation limiting abortions performed after 12 weeks' gestation to hospital in-patients. Rather, experienced clinicians should be allowed to cautiously raise the gestational age threshold for abortions performed in free standing clinics. This will serve to minimize the inconvenience and costs of the procedure, and in some instances, will increase the availability of legal abortion who would be denied such services if it was required that they be performed in hospitals.

(Letter from Dr. Willard Cates to Dr. William McBeath, Executive Director, APHA, January 19, 1979).

Medical evidence is growing and consistent that second trimester procedures can be performed in clinics more safely

with less delay and less cost than previously. Each of these factors has a significant correlation to maternal health. Statutes and ordinances, like the ones at issue require that all second trimester procedures be performed in more expensive, less accessible hospitals. As such, they fly in the face of the policies of medical associations, and the body of medical fact which informs those policies.

II. THE COURT MUST EXAMINE THESE REGULATIONS WITH STRICT SCRUTINY BECAUSE THEY IMPOSE A RESTRICTION ON A FUNDAMENTAL RIGHT.

Amicus submits that the statute and ordinance at issue in these cases warrant strict judicial scrutiny because of the important constitutional right involved. In Roe v. Wade, 410 U.S. 113 (1973), this court held that in the second trimester the state may have a

compelling interest in protecting health which justifies regulations to promote maternal health. This ruling was predicated on the Court's finding that, at that time, 1973, second trimester abortions were as dangerous as childbirth

> With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now established medical fact, ... that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Roe v. Wade, 410 U.S. at 163. (emphasis added)

Because advances in the abortion field have made the procedures safer than childbirth, it is the position of amicus that there is no longer the same reason

for second trimester regulations. Assuming arguendo, however, that the state may lawfully regulate second trimester abortions, the regulation at issue must fall under the standards set by this court in Roe v. Wade, supra, Planned Parenthood of Central Missouri v. Danforth, supra, and subsequent decisions. In Planned Parenthood this court specifically addressed the question of whether a Missouri second trimester restriction on saline abortions, the method then most commonly used in the second trimester was in fact "reasonably related to maternal health", and concluded that, far from promoting a woman's health, the restriction "forc[ed] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 79.

Medical evidence amassed since 1976 strongly indicates that blanket hospitalization requirements for second trimester abortions have the same effect, by prohibiting earlier, safe, less expensive second trimester abortions in clinics.

Amicus urges this court to make its own analysis of the medical evidence as it has done in the past, in judging whether in light of current medical facts, a hospitalization requirement for all second trimester abortions is reasonably related to maternal health. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77.

In Carey v. Population Services International, 431 U.S. 678 (1979) this court clearly stated that regulations which impede access to a reproductive right are to be judged under the same strict standard as those regulations

which prohibit the exercise of the right entirely:

> the same test must be applied to regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to statutes that prohibit the decision entirely.

431 U.S. at 688.

III. THE STATUTE AND ORDINANCE SINGLE OUT ABORTION FOR DIFFERENT TREATMENT IN MEDICAL REGULATION.

Second trimester abortion is the only procedure which the state of Virginia requires to be done in a hospital. Similarly, no medical procedure other than second trimester abortion is the subject of an Akron ordinance limiting performance to a hospital. These regulations, by prohibiting a medical practice, i.e. second trimester abortion in a clinic, which may be safer than the medical practice presecribed by the regulation, i.e. second trimester abortion in a hospital, unnecessarily and unwisely constrain physicians' exercise of their best medical judgment. This court has recognized that the physician's judgment is a strong safeguard of maternal health. See Doe v. Bolton, 410 U.S.

at 192, 195, 197; Planned Parenthood of Central Missouri v. Danforth, 428 U.S. at 77-79.

APHA policy recognizes that second trimester abortions, like the issue of Medicaid funding for abortions, is a favorite target of those who are politically opposed to abortion. APHA Policy No. 7907 "The Right to Second Trimester Abortion" (1979). Statutes and ordinances which single out abortion for unreasonable and unwarranted regulation dissuade doctors from performing abortion.[8] Further, such unwarranted and unreasonable restrictions have the effect of stigmatizing doctors who do perform second trimester abortions. As a consequence, fewer

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8 The experience of the restriction of federal funds for abortion is illustrative of the response by doctors

(footnote continued)

doctors will perform second trimester abortions, thus further limiting the availability of needed abortion services. Given the special risks of pregnancy in the Medicaid eligible population, particularly among teenagers (see Point I.D, supra), Amicus strongly believes that the number of abortions which would have qualified for federal funding would have exceeded 1% of the previous total.

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and hospitals to politically motivated administrative restrictions on medical treatment. The Hyde Amendment prohibited Medicaid payment for abortions not necessary to save the life of the mother. The Hyde Amendment did not prohibit the performance of abortions. See Harris v. McRae, 448 U.S. 297 (1980). After the Hyde Amendment went into effect, less than 1% of the abortions previously performed for Medicaid eligible women were performed and submitted for funding. W. Cates The Hyde Amendment in Action, 246 Journal of the American Medical Association 1109 (1981).

Amicus suggests that, throughout the country, in those states not funding either voluntarily or under court order, doctors are simply refusing to perform or consider abortions for Medicaid elegible women due to the bureaucratic trouble of certification procedures and the fear that their certifications would receive extra-ordinary and unwarranted scrutiny by state or federal authorities.

CONCLUSION

For the foregoing reasons, the Court should hold that state statutes and local ordinances that require

hospitalization for all second trimester abortions are unconstitutional.

Respectfully submitted,

PATRICIA E. HENNESSEY
DAVID B. HOPKINS

Civil Liberties and Public Policy Program
Hampshire College
Amherst, Massachusetts 01002
(413) 549-4600

Attorneys for Amicus Curiae

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OCTOBER TERM, 1982

CITY OF AKRON,

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Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONER, CITY OF AKRON

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN*
MAURA K. QUINLAN
Americans United for Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, Illinois 60601
(312) 263-5029

Counsel for Amicus

July 29, 1982

* Counsel of Record

Midwest Law Printing Co., Chicago 60611, (312) 321-0220

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT:

I.

Appropriate Respect For State Legislative Discretion Requires That Strict Scrutiny Be Invoked Only When Clearly Warranted By The Constitution 4

II.

To Select The Correct Level Of Review For A Law Which Relates To Abortion, A Court Must Determine Whether The Law In Fact Has A Constitutionally Cognizable Impact On The *Roe* Liberty, Whether Any Impact That Does Exist Primarily Benefits Or Burdens Its Exercise, And Whether Any Burden Is Substantial Or Insubstantial 7

A. A Law Which Relates To Abortion But Has No Impact On The *Roe* Liberty Is Constitutional 7

B. A Law Which Impacts On The *Roe* Liberty By Benefiting Its Exercise Invokes Not Strict Scrutiny But Rational Basis Review 12

C. A Law Which Substantially Burdens The *Roe* Liberty Invokes Strict Scrutiny But A Law Which Insubstantially Burdens That Liberty Invokes Only Rational Basis Review 18

III.

A Law Which Relates To Abortion Is Constitutional Unless, When The Impact Of The Law On The *Roe* Liberty Is Considered Together With The State Interests The Law Serves, And These Are Weighed In Accordance With The Applicable Level Of Review, The Law *Unduly* Burdens That Liberty 21

CONCLUSION 26

TABLE OF AUTHORITIES

Cases

Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981) 5, 19
Bellotti v. Baird I, 428 U.S. 132 (1976) 18, 22, 25
Bellotti v. Baird II, 443 U.S. 622 (1979) 20, 22
Carey v. Population Services Int'l., 431 U.S. 678 (1977) 3, 8, 18, 19, 21
Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) 5, 7
Colautti v. Franklin, 439 U.S. 379 (1979) 10
Connecticut v. Menillo, 423 U.S. 9 (1975) 8, 10
Doe v. Bolton, 410 U.S. 179 (1973) 7, 10, 20, 21
Griswold v. Connecticut, 381 U.S. 479 (1965) 18
H.L. v. Matheson, 450 U.S. 398 (1981) 9
Harris v. McRae, 448 U.S. 297 (1980) 7, 9, 17
Maher v. Roe, 432 U.S. 464 (1977) 7, 8, 15, 18, 19, 20, 22
Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307 (1976) 4, 24
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) ..... *passim*
Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*

San Antonio Independent Sch. District v. Rodriguez, 411 U.S. 1 (1973) 13, 14
Whalen v. Roe, 429 U.S. 589 (1977) 8, 10, 11
Wynn v. Scott, 449 F. Supp. 1302 (1978), *aff'd sub nom.* Wynn v. Carey, 559 F.2d 193 (1979) 10

Constitutional Provisions

U.S. Const. amend. V 6
U.S. Const. amend. XIV, § 1 ..... 6, 8

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Zekman & Warrick, The Abortion Profiteers (1978) 23

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BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONER, CITY OF AKRON

INTEREST OF THE *AMICUS CURIAE*

Americans United for Life (AUL) is a national educational foundation organized to promote better understanding of the humanity and value of unborn human life, and to assure equal protection under law for all members of the human family regardless of age, health, or condition of dependency. The national office of Americans United for Life is located in Chicago, Illinois. AUL is supported by thousands of Americans from every state of the union.

SUMMARY OF ARGUMENT

The threshold question in evaluating the constitutionality of abortion-related legislation is whether to employ strict scrutiny or the rational basis standard, a question that often determines whether the law will be stricken or upheld. Due deference to state legislative discretion counsels that strict scrutiny should be invoked only when the Constitution clearly warrants its application, yet lower federal courts have hastened to apply it to virtually all legislation bearing on abortion. There is a need, therefore, for this Court to set out clearly articulated principles governing the application of strict scrutiny to abortion-related legislation. It is the purpose of this brief to set forth those principles as applied in the previous decisions of this Court.

In evaluating the constitutionality of abortion-related legislation, a court should first ask whether a statutory provision impacts on the freedom of choice to abort or bear a child. That liberty has been delineated by this Court, not as a right to abortion, but as a right to choose and to have safe access to the effectuation of that choice. Laws which do not create obstacles in the way of an abortion do not impact on the liberty, whether they are laws which may influence a woman to carry her child to term, laws which impact on physicians who provide abortions, laws which assure the medical consultation without which the liberty does not exist, or laws protective of the fetus or of other state interests. Therefore, such laws are constitutional.

The court's second inquiry should be whether statutory provisions that do impact on the *Roe* liberty do so in a manner that benefits or burdens its exercise. To

the extent that a provision enhances the exercise of the liberty, it should not be subject to strict scrutiny. The rationale behind strict scrutiny is that heightened judicial vigilance is called for when a legislature acts to threaten a fundamental right. This rationale disappears when the effect of the enactment is to foster the right. This conclusion, which is congruent with the conduct of the Court in previous cases, has implications for issues currently before this Court. It suggests that laws in areas such as informed consent, pathological reporting, and hospitalization and waiting period requirements may be subject only to rational basis review since the impact of such provisions on the *Roe* liberty may be primarily to benefit its exercise.

The Court's third inquiry should be whether any burden that does exist is substantial or insubstantial. Under *Carey v. Population Services*, 431 U.S. 675, 688 & 688n.5 (1977), only laws that completely prohibit or substantially restrict access to abortion are subject to strict scrutiny. If the burden is only insubstantial, the rational basis test applies.

Once the court has established the standard of review, it must apply it to particular circumstances in order to determine whether the provisions at stake "unduly burden" the *Roe* liberty. In the case of provisions which both benefit and burden the liberty, the court must analyze the benefit and burden to decide which outweighs the other. The provisions should be upheld as constitutional unless, when weighed against the benefit to the protected interests of the pregnant woman and against any other state interests at stake, the burden associated with the provisions is found to be "undue."

ARGUMENT

I.

APPROPRIATE RESPECT FOR STATE LEGISLATIVE DISCRETION REQUIRES THAT STRICT SCRUTINY BE INVOKED ONLY WHEN CLEARLY WARRANTED BY THE CONSTITUTION.

The threshold issue arising in the context of a case that involves abortion legislation—or, indeed, any legislation that implicates a fundamental right—concerns the appropriate judicial posture in considering the constitutionality of the law. The question is whether the challenged provision warrants "close" or "strict" judicial scrutiny, or whether it merits the "relatively relaxed" "rational-basis standard." *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976).

The answer to this initial inquiry will often predetermine the outcome of the ensuing judicial analysis. Few laws can withstand the systematic scepticism appropriate to heightened judicial scrutiny. Of the hundreds of thousands of statutes, ordinances, and regulations that have issued from our various legislative bodies few relate to such traditionally vital concerns or immediately urgent matters that they serve "compelling" interests. Even fewer are drawn with such fine precision and careful attention to individual circumstances that they are "narrowly drawn" to serve only compelling governmental interests. *See* Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 Harv. L. Rev. 1, 8 (1972).

On the other hand, few laws fail to serve some "valid" or "legitimate" governmental interest, and few of those that do are so incoherent or misdirected that they bear

no conceivable "rational relation" to the valid interests they purport to serve. See *id.*

The question whether strict or relaxed scrutiny of a law is appropriate implicates issues central to the proper role of the judiciary and the posture it should take toward the legislature. Applying strict judicial scrutiny to duly enacted legislation when not clearly required by the Constitution provides insufficient deference to the legislature, an equal branch of government, and to the democratic process which generates statutory law.

"Strict scrutiny" flows from the duty of the judiciary to protect constitutionally recognized rights from overbearing democratic majorities. At the same time, strict scrutiny should not be employed unless the law at issue clearly and substantially limits the exercise of some fundamental right. Unwarranted use of this ultimate weapon in the judicial arsenal implies insufficient respect for legislative rights and the integrity of the democratic process.

The Sixth Circuit in this case hastened to apply strict scrutiny to virtually any legislation that bears upon abortion. *Akron Center for Reproductive Health v. City of Akron*, 651 F.2d 1198, 1203-1204 (6th Cir. 1981); *see also, Charles v. Carey*, 627 F.2d 772, 776-78 (7th Cir. 1980). To avoid such errors, there is a pressing need for this Court clearly to articulate the principles to be used in selecting the appropriate standard for reviewing abortion related legislation.

The limited purpose of this brief is to assist the Court in that task by distilling a basic framework of analysis from this Court's previous opinions.

This framework suggests that a court reviewing legislation relating to abortion should first ask whether

the legislation's provisions in fact impact on the liberty recognized in *Roe v. Wade*, 410 U.S. 113 (1973). If they do not, a challenge based on the Due Process Clauses of the Fifth and Fourteenth Amendments should fail, while one based on the equal protection components of these amendments should be examined under the rational basis standard. See this brief at p. 17 n. 5.

Second, the Court should ask whether legislation which does have an impact on the *Roe* liberty primarily benefits the exercise of that right. If it does, even if its impact on the liberty is substantial, it should be examined under the rational basis standard—unless it also creates a substantial burden on the liberty.

Third, the court should ask whether the provisions which do burden the exercise of the liberty do so substantially or insubstantially. Only substantial burdens should invoke strict scrutiny. Otherwise the rational basis standard should apply.

Once the proper level of review has been selected, the court should apply the well-established criteria for balancing the rights of the pregnant woman against the interests of the State. When dealing with provisions which benefit as well as burden the liberty at stake, however, the court should carefully balance the benefit and the burden, employing whichever standard of review is applicable, to ensure that the provision is declared unconstitutional only if the burden is "undue."

II.

TO SELECT THE CORRECT LEVEL OF REVIEW FOR A LAW WHICH RELATES TO ABORTION, A COURT MUST DETERMINE WHETHER THE LAW IN FACT HAS A CONSTITUTIONALLY COGNIZABLE IMPACT ON THE *ROE* LIBERTY, WHETHER ANY IMPACT THAT DOES EXIST PRIMARILY BENEFITS OR BURDENS ITS EXERCISE, AND WHETHER ANY BURDEN IS SUBSTANTIAL OR INSUBSTANTIAL.

A. A Law Which Relates To Abortion But Has No Impact On The *Roe* Liberty Is Constitutional.

As the Seventh Circuit Court of Appeals correctly recognized, "a law is not considered an interference with the pregnancy termination decision and subject to strict scrutiny simply because it concerns abortion." *Charles*, 627 F.2d at 776. "[T]he right in *Roe v. Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it." *Maher v. Roe*, 432 U.S. 464 (1977).

In the first place, the law must have an impact on some recognized facet of the abortion liberty. What is that liberty?

"The constitutional right vindicated in *Doe* [*v. Bolton*, 410 U.S. 179 (1973) and *Roe v. Wade*] was the right of a pregnant woman to decide whether or not to bear a child without unwarranted state interference." It is a "freedom of personal choice." *Harris v. McRae*, 448 U.S. 297, 312 (1980). This constitutionally secured right "protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." *Maher*, 432 U.S. at 473-74. The liberty secured in *Roe v. Wade* is "not . . . an unqualified constitutional right to an abortion" but rather "a constitutionally protected interest 'in making [a] certain kind of important decision . . .' free from governmental

compulsion." *Id.* at 473 (quoting *Whalen*, 429 U.S. 589, 599-600 & nn. 24 & 26 [1977]). "A woman has at least an equal right to choose to carry her fetus to term as to choose to abort it." *Maher*, 432 U.S. at 472 n. 7.

As a necessary corollary to freedom to decide, the right secured in *Roe* also protects "the effectuation of [the] decision from unduly burdensome state-created obstacles." *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 70 n. 11 (1976). Thus, *access* to both childbirth and abortion is an important aspect of the *Roe* liberty. "[S]uch access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the holdings in . . . *Roe v. Wade.*" *Carey v. Population Services International*, 431 U.S. at 688-89.

In addition to choice and access, *safety* is the third recognized aspect of the abortional liberty. *Roe v. Wade* recognized "a woman's right to clinical abortion by medically competent personnel." *Connecticut v. Menillo*, 423 U.S. 9, 10 (1975). "Jane Roe had sought to have an abortion 'performed by a competent, licensed physician, under safe, clinical conditions,' [*Roe*, 410 U.S. at 120], and our opinion recognized only her right to an abortion under those circumstances." *Id.* The Constitution protects access only to "an abortion 'performed . . . under safe, clinical conditions,' [*Roe*, 410 U.S. at 120]." *Connecticut v. Menillo*, 423 U.S. at 10. Safety is an essential attribute of the right: "Our opinion recognized *only* [the] right to an abortion *under those circumstances.*" *Id.* (emphasis added). The State has no constitutional obligation to permit unsafe conditions in the performance of abortions.

The Fourteenth Amendment, then, protects from unduly burdensome state interference *choice* between

childbirth and abortion, and *access* to both under *safe* conditions.

When can it be said that a state action impacts on this constitutionally protected right?

Laws do not impact on the *Roe* liberty merely because they influence the woman to carry her child to term. "The Constitution does not compel a State to fine-tune its statutes so as to encourage or facilitate abortions. To the contrary, state action 'encouraging childbirth except in the most urgent circumstances' is 'rationally related to the legitimate governmental objective of protecting potential life.'" *H. L. v. Matheson*, 450 U.S. 398, 413 (1981) (*quoting Harris v. McRae*, 448 U.S. at 325. Thus, a law does not have an impact on the liberty to choose merely because it discourages abortion or makes it less likely that a woman will choose abortion. Moreover, the *Roe* liberty assures only that "government may not place obstacles in the path of a woman's exercise of her freedom of choice." It does not require the government to "remove those not of its own creation." *Harris*, 448 U.S. at 316. For this reason, neither a governmental failure to subsidize the effectuation of the constitutionally protected choice, nor an unequal subsidization of the protected alternatives in that choice—childbirth or abortion—has a constitutionally cognizable impact on the liberty recognized in *Roe*.

It is also clear that, because the *Roe* liberty is personal to the pregnant woman, third-party providers of services related to the woman's protected choice can assert no rights independent of those of the pregnant woman. Thus, for example, "statutory restrictions on . . . abortion procedures [may be] invalid because they [encumber] the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she [is] entitled to rely for advice

in connection with her decision." If, however, "those obstacles [do not impact] upon the woman's freedom to make a constitutionally protected decision, if they . . . merely [make] the physician's work more laborious or less independent without any impact on the patient, they [do not violate] the Constitution." *Whalen*, 429 U.S. at 605 n. 33.

At the same time, the liberty exists only within the context of consultation with a physician. "[T]he attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. *If* that decision is reached, the judgment may be effectuated by an abortion free of interference by the State." *Roe*, 410 U.S. at 163 (emphasis added). The Court has upheld, therefore, a criminal ban on all abortions with regard to which a physician has not made a determination "based on his best clinical judgment that an abortion is necessary." *Doe v. Bolton*, 410 U.S. at 191. The Supreme Court has "stressed repeatedly the role of the physician . . . in consulting with the woman whether or not to have an abortion. . . ." *Colautti v. Franklin*, 439 U.S. 379, 387 (1979). *See also Connecticut v. Menillo*, 423 U.S. at 10. Laws that prevent abortions obtained without appropriate medical consultation, therefore, do not impact on the protected right.

Finally, the "constitutional right vindicated" is that "of a pregnant woman to decide whether or not to *bear* a child." *Whalen*, 429 U.S. at 605 n. 33 (emphasis added). It does not restrain the State from preventing hostile activity directed toward the fetus unrelated to the woman's interest in choosing whether or not to remain pregnant. *See Wynn v. Scott*, 449 F.Supp. 1302, 1321 (1978), *aff'd sub nom. Wynn v. Carey*, 559 F.2d 193 (1979) (the right secured in *Roe* is to expel contents of

the uterus, not to ensure the death of the fetus.) State regulation of abortion is not limited by the Constitution as a matter of absolute, abstract principle, but only to the extent that such regulation unduly burdens or obstructs the exercise of the woman's choice to terminate pregnancy or carry a child to term. Thus, regulation of abortion on behalf of maternal health, on behalf of the fetus, or on behalf of any other state interest—even in the first trimester—does not automatically trigger strict scrutiny. It does so only if it obstructs exercise of the right secured in *Roe*.

In sum, to have a constitutionally cognizable impact on the abortion liberty recognized by this Court, statutory provisions must impose a state-created restriction on the "choice," "access" or "safety" facets of the abortional liberty. If they do not—if they merely touch or relate to abortion without "impact[ing] upon the woman's freedom to make a constitutionally protected decision" (*Whalen*, 429 U.S. at 605)—they are not unconstitutional.

Laws do not impact on the liberty recognized in *Roe* merely because they discourage abortion or make it less likely that the woman will procure abortion, deny governmental assistance for abortion, merely make the physician's work more laborious or difficult, foreclose performance of abortion without appropriate medical assistance or consultation, or regulate aspects of abortion that do not relate to the woman's right to be free of a pregnant condition. Such laws do not even implicate the liberty acknowledged in *Roe* and are therefore constitutional.

B. A Law Which Impacts On The *Roe* Liberty By Benefiting Its Exercise Invokes Not Strict Scrutiny But Rational Basis Review.

Once it has been determined that a challenged statutory provision does have a constitutionally cognizable impact on a recognized facet of the abortion liberty, the next question is whether that impact is primarily positive or negative. A law which serves primarily to *enhance* the exercise of the liberty should not be subject to strict scrutiny. This is the case even if there are restrictions on the liberty's exercise incident to the primarily beneficial effect, so long as such incidental restrictions do not amount to a substantial burden on its exercise.[1]

The notion behind strict scrutiny is that a heightened level of judicial vigilance is necessary when a legislature embarks on a course of action which threatens fundamental rights protected by the Constitution, because such a course of action is prima facie suspicious. But when a legislature acts in a manner that genuinely facilitates the exercise of a right, the rationale for heightened scrutiny disappears, and its application can be counterproductive.[2]

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[1] *See* Section II C, *infra*. There are few benefits without burdens. Even the simple and beneficially protective traffic signal causes a delay in travel. So it is with abortion. *Any* restriction in some sense burdens access: consider the physician requirement discussed above. Only when the burdens inevitably incident to any benefit are substantial should they trigger strict scrutiny. Of course, whatever the level of review, burdens of any nature, substantial or not, must be weighed against the benefits to determine if the burdens are "undue." See Section III for a discussion of the analysis appropriate to such a weighing, which is not pertinent to the threshold determination of what should be the level of review.

[2] Consider, for example, what would happen if the physician requirement were to be subjected to strict scrutiny. Assuming that it passed the "ends" test of being justified by a compell-

(Footnote continued on following page)

In *San Antonio Independent Sch. District v. Rodriguez*, 411 U.S. 1, 17 (1973) the Court declined to apply strict scrutiny to a public education financing system which allegedly discriminated in the provision of education on the basis of wealth. The Court said,

> We find this a particularly inappropriate case in which to subject state action to strict judicial scrutiny. The present case, in [a] basic sense, is significantly different from any of the cases in which the Court has applied strict scrutiny . . . . Each of our prior cases involved legislation which "deprived," "infringed," or "interfered" with the free exercise of some . . . fundamental personal right or liberty. A critical distinction between those cases and the one now before us lies in what Texas is endeavoring to do with respect to education. . . . Every step leading to the establishment of the system Texas utilizes today . . . was implemented in an effort to *extend* public education and to improve its quality. . . . [W]e think it plain that, in substance, the thrust of the Texas system is affirmative and reformatory and, therefore, should be scrutinized under judicial

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[2] *continued*

ing state interest, it would still have to be analyzed under the "means" requirement that it be narrowly drawn. It could well be argued that the physician requirement was both unconstitutionally overinclusive and underinclusive: overinclusive because it banned abortion performed, for example, by experienced midwives who could provide safe abortions; underinclusive because it permitted abortion by, for example, ophthamologists without the experience or expertise necessary to make an abortion safe. Were a strict scrutiny level of review imposed, it might lead to the conclusion that the only constitutional approach to the matter would be the administration of some kind of abortion proficiency test to aspiring laymen and physicians alike in order to select qualified abortion practitioners. Clearly, the Court has deemed so strict an approach inappropriate to impose upon States seeking to ensure the woman's safety, and thus benefit the *Roe* liberty, by legislating that only physicians may perform abortions.

> principles sensitive to the nature of the State's efforts and to the rights reserved to the States under the Constitution.

Id. at 37-39 (citations omitted) (emphasis in original).

Although some courts have read *Roe* to prohibit all regulation during the first trimester except when the State has a "compelling interest" which justifies its regulation, uniform application of strict scrutiny to first trimester regulations is unwarranted.

In *Danforth*, this Court upheld state abortion regulations which applied to the first trimester without applying strict scrutiny. In their concurring opinion, Justices Powell and Stewart emphasized the basic difference between regulations intended to enhance the woman's exercise of her fundamental right and those intended to burden it.

> While [the informed consent provision] obviously regulates the abortion decision during all stages of pregnancy, including the first trimester, I do not believe that it conflicts with [*Roe*, where the Court stated that during the first trimester the woman, in consultation with her physician, is free to determine to abort without state interference, 410 U.S. at 163, because] [t]hat statement was made in the context of a law aimed at thwarting a woman's decision to have an abortion. It was not intended to preclude the State from enacting a provision aimed at ensuring that the abortion decision is made in a knowing, intelligent, and voluntary fashion.

428 U.S. at 89-90 (Stewart, J. concurring).

The Court also upheld recordkeeping requirements applicable to the first trimester. Noting that "maintenance of records . . . may be helpful in developing information pertinent to the preservation of maternal health", the Court said, "Recordkeeping of this kind, if not abused

or overdone, can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment." *Id.* at 80, 81. Thus, a law that actually enhanced the pregnant woman's health interest was examined under the rational basis test, even though it regulated abortion in the first trimester.

In so doing, this Court has recognized that abortion regulations may be motivated by one of two very different types of concerns. One is on behalf of the fetus,[3] an interest adverse to the constitutionally protected interest of the pregnant woman. Regulation on behalf of the fetus is by no means inherently unconstitutional, or even inherently subject to strict scrutiny. Such regulation does necessarily require, however, that the weight of the state interest be balanced against that of the pregnant woman's constitutionally protected interests.

On the other hand, the effect of a State action may genuinely weigh in favor of the woman's interests—a regulation may foster and enhance the exercise of her liberty. In such a case, unless the regulation also entails a substantial burden on the *Roe* liberty, there is no logical reason to employ strict scrutiny merely because the impact of the regulation on the liberty is substantial.

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[3] Theoretically, the State could seek to further other interests adverse to those of the pregnant woman through abortion regulation. *Roe* briefly mentioned, for example, the possibility of a "concern to discourage illicit sexual conduct." 410 U.S. at 148. (As *Roe* pointed out, however, no one, including any defender of state statutes, "has taken the argument seriously." *Id.*) *Maher v. Roe*, 432 U.S. at 478 n. 11, notes the possibility of demographic interests in a State's "rate of population growth."

This Court's decision in *Danforth*, therefore, demonstrates that a threshold determination concerning whether the primary impact of the challenged statutory provision enhances or encumbers the *Roe* liberty is crucial in selecting the proper level of review. This principle has implications for some of the kinds of state laws relating to abortion now before this Court for review.

For example, laws that ensure that a woman contemplating the choice between abortion and childbirth be given information material to her decision tend to enhance the "choice" aspect of the *Roe* liberty. It is inappropriate to apply strict scrutiny to such laws merely because they have an impact on the *Roe* liberty if they in fact servc the very interest the liberty protects: the interest of the woman in making a voluntary, competent, and autonomous choice whether or not to carry a child to term. Of course, to achieve this result the legislation must in fact genuinely enhance the possibility of free and reflected choice. To the extent such laws purvey what is false, misleading, confusing or inflammatory (as opposed to informative) they do not enhance but burden the choice.[4] But a law that merely requires that women be provided with certain objective

[4] Such circumstances, which vitiate the potentially beneficial aspects of informed consent, are to be distinguished from circumstances which may create burdens incidental to still present beneficial aspects. For example, the sheer volume of data that must be provided to the woman might create a burden. This volume would not remove the benefit, but might outweigh it. The proper analysis is to weigh such a burden against the benefit to determine if the burden is "undue" and thus if the legislation is unconstitutional as discussed in Section III. By contrast, the threshold question, discussed here, is whether the challenged provision in fact benefits the liberty —even if it also has burdensome aspects—or only purports to do so, in order to establish the correct standard of review.

information that may materially affect the outcome of their decisions between childbirth and abortion should not for that reason be subjected to strict scrutiny, because such a law fosters, rather than inhibits, the constitutionally protected liberty.

In sum, a court considering a challenge to a legislative provision that impacts on the *Roe* liberty should determine whether the provision has the primary effect of enhancing some aspects of that liberty's exercise. If it does, then unless the provision carries a concomitant burden on the liberty which is *substantial* (see the next section of this brief), the Court should employ the rational basis standard in deciding the constitutionality of the provision.[5]

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[5] If a statutory provision literally has no constitutionally cognizable impact on the liberty recognized in *Roe* (*see* Section IIA of this brief), constitutional analysis ends with this conclusion. There is no need to apply the rational basis test because that which has no adverse burden *at all* on constitutionally protected rights need not even be justified by a state interest. (This changes if, in addition to or instead of a substantive due process violation, an equal protection violation is alleged. In such a case, a determination that no fundamental right is infringed—or suspect class discriminated against—means only that strict scrutiny need not be employed; the rational basis test must still be met. *Cf.* the treatment in *Harris* of a substantive due process challenge, 448 U.S. at 312-18 with the treatment in the same case of an equal protection challenge, *id.* at 321-26.) In the abstract, a statutory provision whose sole impact on the protected liberty was held to be to benefit its exercise would also require no further constitutional scrutiny. In fact, however, any provision with a constitutionally cognizable but beneficial impact on the liberty will also burden it, no matter how minimally, by limiting access or at least slightly increasing the cost of effectuating a choice. Although an insubstantial burden does not invoke strict scrutiny (*see* Section II C), the fact that it is a burden means that the provision imposing it must undergo rational basis review. This is so because even an insubstantial burden might be "undue" if it was not rationally related to a legitimate state interest.

C. A Law Which Substantially Burdens The *Roe* Liberty Invokes Strict Scrutiny But A Law Which Insubstantially Burdens That Liberty Invokes Only Rational Basis Review.

This Court's clearest description of the degree of burden requisite to trigger strict scrutiny of abortion-related legislative provisions came in *Carey v. Population Services*, 431 U.S. at 688 (emphasis added):

> [T]he same test must be applied to state regulations that burden an individual's right to decide to . . . terminate pregnancy by *substantially* limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely. Both types of regulation "may be justified only by a 'compelling state interest' . . . and . . . must be narrowly drawn to express only the legitimate state interests at stake." *Roe v. Wade*, 410 U.S. at 155.

Justice Powell, concurring in part and concurring in the judgment, voiced his objection to what he saw as an unwarranted imposition of the strict scrutiny standard of review. "In my view, [*Griswold v. Connecticut*, 381 U.S. 479 (1965) and *Roe*] make clear that that standard has been invoked only when the state regulation entirely frustrates or heavily burdens the exercise of constitutional rights in this area. See *Bellotti v. Baird* I, 428 U.S. at 147." *Carey*, 431 U.S. at 705.

The Court specifically responded to Justice Powell's criticism by emphasizing that "state regulation must meet this standard . . . *only* when it 'burden[s] an individual's right to decide to prevent conception or terminate pregnancy by *substantially* limiting access to the means of effectuating that decision.'" *Id.* at 688 n. 5 (emphasis added).

The Sixth Circuit held below that *any* "'direct state interference with a protected activity' [quoting *Maher*,

432 U.S. at 475], here the right of a pregnant woman to have an abortion, . . . is subject to strict scrutiny" and that, "[s]ince the state has no compelling interest during the first trimester . . . [i]f a regulation results in a legally significant impact or consequence on a first trimester abortion decision, it is invalid." *Akron*, 651 F.2d at 12-4. These holdings contradict this Court's ruling in *Carey* and badly misconstrue its holdings in *Danforth*.

In *Danforth*, the Court upheld informed consent (428 U.S. at 65-67) and recordkeeping requirements (*id.* at 79-81) that applied throughout pregnancy, including the first trimester. The Sixth Circuit sought to distinguish these holdings by describing them as "based upon a finding that neither provision involved an intrusion into the decision-making process sufficient to require constitutional analysis[,] . . . not . . . on a holding that the constitutionality of the statute could rest on something less than a compelling state interest." *Akron*, 651 F.2d at 1203. This plainly mischaracterizes the *Danforth* opinion. Rather than treating the informed consent and recordkeeping requirements as though neither "raise[d] a constitutional issue" nor needed to be examined "to determine whether or not the regulatory provision serves a legitimate and [sic] compelling state interest" (*id.* at 1204), the Court related each to a state interest. The informed consent provision was related to the interest in assuring that the "decision to abort . . . be made with full knowledge of its nature and consequences." *Danforth*, 428 U.S. at 67. The recordkeeping provision was related to "the State's interest in protecting the health of its female citizens" and in developing a statistical "resource that is relevant to decisions involving medical experience and judgment." *Id.* at 81.

The section of *Danforth* dealing with the record-keeping requirement, in particular, contains a nuanced discussion of the "important and perhaps conflicting interests affected." *Id.* at 80. The Court did *not* deem "constitutional analysis" unnecessary. On the contrary, it carefully weighed and balanced these interests before holding the provision constitutional. What it did was to apply constitutional analysis in accord with a lower standard of review than strict scrutiny.

This Court has explicitly applied strict scrutiny to invalidate state abortion statutes in only three types of situations, summarized in *Maher*, 428 U.S. at 472-473.

First, strict scrutiny has been applied where a law prohibits abortion altogether. *Roe*, 410 U.S. at 153; *Doe v. Bolton*, 410 U.S. at 200-201 (out-of-state residents). (*See also Danforth*, 428 U.S. at 81-84, in which the Court struck a standard of care provision which "effectively preclude[d] abortion.")

Second, it has been applied where a State seeks to give the decision whether or not to abort to a person other than the pregnant woman herself through some form of "third party veto." *Danforth*, 428 U.S. at 67-75 (spousal consent and parental consent provisions invalidated); *Bellotti v. Baird* II, 443 U.S. 622, 642-644 (1979) (parental and judicial consent invalidated). The "third-party veto" rulings may be viewed simply as delegated powers of prohibition (*cf. Danforth*, 428 U.S. at 69). *Doe v. Bolton*'s strict scrutiny of the hospital committee and two doctor concurrence requirements (410 U.S. at 198), fit within the same framework.

Third, strict scrutiny has been applied where state regulation has so substantially limited access to abortion that a pregnant woman is almost precluded from effectuating her decision to abort. For example, in

Danforth, 428 U.S. at 75-79, the Court invalidated a statute which prohibited saline amniocentesis as a method of abortion. In striking the statute, the Court relied on the fact that "there were severe limitations on the availability of the prostaglandin technique," the alternative to the saline procedure. *Id.* at 77 n. 12. In their concurring opinions, Justices Powell, Stevens and Stewart felt that the statute could be invalidated only because "a prohibition of the saline amniocentesis procedure was *almost tantamount* to a prohibition of any abortion in the State after the first 12 weeks of pregnancy." *Id.* at 92, 102 (emphasis added). Similarly, the Court in *Doe v. Bolton* strictly scrutinized the Georgia requirement that abortions be performed only in hospitals accredited by the Joint Commission on Accreditation of Hospitals because it substantially burdened access to abortion. *Id.* at 193-195.

Thus, this Court, in accord with the *Carey* criteria, has never applied strict scrutiny to an abortion law except when it has found that the law imposed a complete prohibition or substantial burden. It follows that the constitutionality of state regulations that impose only *insubstantial* burdens should be evaluated under the rational basis level of review.

III.

A LAW WHICH RELATES TO ABORTION IS CONSTITUTIONAL UNLESS, WHEN THE IMPACT OF THE LAW ON THE *ROE* LIBERTY IS CONSIDERED TOGETHER WITH THE STATE INTERESTS THE LAW SERVES, AND THESE ARE WEIGHED IN ACCORDANCE WITH THE APPLICABLE LEVEL OF REVIEW, THE LAW *UNDULY* BURDENS THAT LIBERTY.

This Court has "held that a requirement for a lawful abortion 'is not unconstitutional unless it unduly bur-

dens the right to seek an abortion.'" *Maher*, 432 U.S. at 473 (*quoting Bellotti v. Baird* I, 428 U.S. at 147). Once the threshold evaluation has been made and the proper level of review has been selected, it remains to determine whether any "burden" that has been found—"substantial" burden if the strict scrutiny test has been invoked or "insubstantial" burden if the rational basis test is to be employed—is "undue" by weighing that burden against the legitimate or compelling state interests that the burdensome provision advances. This requires testing the sufficiency of the State's "ends" and the appropriateness of the State's "means". The standards for each prong depend on which level of review has been invoked.

Roe explicitly acknowledged two state interests which are "legitimate" throughout pregnancy and which became "compelling" at different stages: the interest in maternal health and the interest in the fetus. 410 U.S. at 162-64.

Subsequent to *Roe*, the Court has acknowledged other interests at stake in an exercise of the *Roe* liberty: in assuring the mutuality of the marital relation and in the paternal interest in the fetus, *Danforth*, 428 U.S. at 67; in assuring the integrity of the woman's decision, *Danforth*, 428 U.S. at 67; in protection of the immature minor and of the interests of her parents, *Bellotti v. Baird* II, 443 U.S. at 635, 637; in development of public health data, *Danforth*, 428 U.S. at 80-81; and in population control, *Maher*, 432 U.S. at 478 n. 11.

Whatever other legitimate or compelling interests a State may have, one which protects the fundamental rights of its citizens must certainly be called compelling. Yet, it is compelling only to the extent that the

provision does foster a fundamental right; and it fosters it only when, on balance, the beneficial effects of the provision outweigh the burdensome effects. It is necessary, therefore, whatever level of scrutiny is used, to weigh the burden against the benefit to see if, in light of the comparative substantiality of the benefit and the burden, the burden is "undue."

For example, consider the constitutionality of a waiting period. A brief waiting period may substantially enhance the prospect of reflected and thereby autonomous rather than coerced or unduly pressured decisions—thus benefiting the "choice" aspect of the *Roe* liberty. In an abstract sense, it might be argued that the greater the time for reflection, the more free and autonomous the choice is likely to be. It seems clear, however, that the benefit is most substantial in association with the first hours or days of a waiting period. It is then that the need is greatest to calm the panic that may accompany discovery of pregnancy, or to withdraw from the perhaps huckstering pressures of an abortion clinic. *See generally* Zekman & Warrick, *The Abortion Profiteers* (1978) (special reprint of *Chicago Sun-Times* series on undercover investigation of abortion clinics). As the waiting period lengthens, the substantiality of the marginal benefit decreases. At the same time, a waiting period of any length burdens the "access" aspect of the same liberty by restricting immediate effectuation of a decision to abort. The substantiality of the burden on access—and perhaps, as the pregnancy progresses, on safety—increases steadily as the waiting period grows longer. Thus, a one day waiting period might greatly enhance the quality of choice while only minimally diminishing access. On the other hand, a one week waiting period would much more substantially diminish ac-

cess, while the marginal benefit to choice of such a length might well be insubstantial.

Similarly, a properly drawn informed consent provision could benefit the liberty recognized in *Roe* by enhancing the autonomy of the woman's choice. Incidentally, it would also burden that liberty by causing a minimal delay, thus affecting access—a burden that in most cases would be so slight as to be *de minimis*. If, however, an otherwise beneficial informed consent regulation were so unreasonable as to require an entire course on fetal development, the substantial delay would overcome the benefit.

Once the nature and weight of the state interests at stake have been identified, and even if they are held sufficient to justify the statutory provision, a "means" analysis testing the relationship of the law to the state interests is still necessary. Under strict scrutiny, the "legislative enactments must be narrowly drawn" (*Roe*, 410 U.S. at 155) in order to further the state interests in a manner which burdens the liberty to the minimum extent necessary to serve those interests. Under the rational basis standard, the enactment need only "rationally further the purpose identified by the State." *Murgia*, 427 U.S. at 314. The significance of the principle that laws which benefit the exercise of the *Roe* liberty are subject to the rational basis test is greatest when the "means" prong is reached. (It makes little difference to the constitutionality of such laws whether the "ends" prong of strict scrutiny or of rational basis review is applied, since, as we have seen, state action which benefits the exercise of a fundamental right by definition serves a compelling state interest.)

Danforth's analysis of the Missouri recordkeeping requirements provides a paradigm for this sort of analy-

sis. The manner in which the Court effectively employed a rational basis rather than a strict scrutiny test has already been discussed. *See* brief at 14-15. The Court carefully weighed the "important and perhaps conflicting interests affected by recordkeeping requirements": the benefit of "the preservation of maternal health" against the burden of "restrictions or regulations governing the medical judgment of the pregnant woman's attending physician with respect to the termination of her pregnancy." 428 U.S. at 80. It concluded that the benefits were important and useful, while the burdens, given a strict protection of confidentiality and a reasonable limit of 7 years for the records' required retention, were not of "significant impact or consequence." *Id.* at 81. The Court warned, however, that were there to be a "sheer burden of recordkeeping detail," the burden could become substantial enough to alter this balance and render a recordkeeping requirement unconstitutional. As for the "means" prong of the test, the Court regarded the requirements to be "reasonably directed to the preservation of maternal health." *Id.* at 80.

Thus, conscientious constitutional analysis requires, not a mechanistic striking of any law that impacts on abortion in the first trimester, but a careful weighing of the benefits and burdens it creates for the *Roe* liberty, as well as of the state interests at stake. Unless, all things considered, "it unduly burdens the right to seek an abortion," *Bellotti* I, 428 U.S. at 147, such a law should be upheld.

CONCLUSION

Proper evaluation of constitutional challenges to statutory provisions that relate to abortion requires a two-step process.

Initially, a court must make a threshold examination to determine what level of review, if any, is appropriate. To do so, the court should first consider whether a statutory provision has a constitutionally cognizable impact on the *Roe* liberty as that liberty is properly understood. If it does not, the law should be upheld if the challenge is based on a due process claim and subjected to a rational basis review if the challenge is based on an equal protection claim.

Second, if there is an impact, the Court should consider whether the impact primarily benefits or burdens the exercise of the *Roe* liberty. If the impact is primarily beneficial, and if any attendant burden is insubstantial, the provision should be subjected to rational basis scrutiny.

Third, if the challenged provision carries a burden on the *Roe* liberty, the Court must determine whether that burden is substantial or insubstantial. If the burden is substantial, the strict scrutiny test is appropriate, but if the burden is insubstantial, the rational basis test should be applied.

Once the threshold is crossed and the level of review is selected, the procedure for evaluation is well settled. Under the strict scrutiny test the Court should determine whether the provision is supported by any compelling state interests, and if so, whether the provision is narrowly drawn to serve only those interests. Under the rational basis test, the Court should determine if the

provision is supported by any legitimate state interests and, if so, whether the provision is rationally related to those interests. When the provision benefits as well as burdens the exercise of the *Roe* liberty, however, the Court must balance the nature and degree of the burden against the nature and degree of the benefit. Unless, given the benefit and any other interests at stake, the burden is "undue," the provision should be upheld as constitutional.

Respectfully submitted,

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN*
MAURA K. QUINLAN
Americans United for Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, Illinois 60601
(312) 263-5029
Counsel for Amicus

July 29, 1982

* Counsel of Record

Law Students Who Assisted in the Preparation of this Brief: Daniel Avila, Thomas J. Balch, Elizabeth Bower, Michael R. Carey, Richard Cohen, Walter M. Weber.

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Nos. 81-746 and 81-1172

IN THE

Supreme Court of the United States

October Term, 1982

CITY OF AKRON, *et al.*,

Defendants-Petitioners,

vs.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Plaintiffs-Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Plaintiffs-Petitioners,

vs.

CITY OF AKRON, *et al.*,

Defendants-Respondents.

On Certiorari to United States Court Of Appeals for the Sixth Circuit.

BRIEF AMICI CURIAE OF CALIFORNIA WOMEN LAWYERS AND WOMEN LAWYERS' ASSOCIATION OF LOS ANGELES.

SUSAN LERNER,
One Wilshire Blvd.,
Suite 1600,
Los Angeles, Calif. 90017,
(213) 629-0200.

SHERRI M. KIRK,
261 S. Figueroa Street,
Suite 210,
Los Angeles, Calif. 90012,
(213) 624-5112.

INDEX

	Page
Interest of the Amici	1
Summary of Argument	3
Argument:	
I. The constitutionality of the challenged abortion regulations, as with all regulations affecting fundamental rights, should be determined by this Court, not state legislatures	5
II. Abortion restrictions may be justified only by a compelling state interest and must be narrowly drawn	14
III. The Akron abortion restrictions are not justified by a compelling state interest and are not narrowly drawn . .	19
Conclusion	28

TABLE OF AUTHORITIES

Cases	Page
Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981)	22
Baker v. Carr, 369 U.S. 186 (1962)	9
Bellotti v. Baird, 428 U.S. 132 (1976)	17
Bellotti v. Baird, 443 U.S. 662 (1979)	17, 20
Carey v. Population Services International, 431 U.S. 678 (1977)	16
Cohens v. Virginia, 6 Wheat. 264 (1821)	9, 11
Columbia Broadcasting System, Inc. v. Democratic National Committee, 412 U.S. 94 (1973)	12
Cooper v. Aaron, 358 U.S. 1 (1958)	9
Doe v. Bolton, 410 U.S. 179 (1973)	27
Dunn v. Blumstein, 405 U.S. 330 (1972)	15

Eisenstadt v. Baird, 405 U.S. 438 (1972) 14

Fletcher v. Peck, 6 Cranch 87 (1810) 9

Fullilove v. Klutznick, 448 U.S. 448 (1980) 12

Fusari v. Steinberg, 419 U.S. 379 (1975) 25

Gary-Northwest Indiana Women's Services, Inc. v. Bowen, 421 F. Supp. 734 (N.D. Ind. 1976), aff'd 429 U.S. 1067 (1977) . . 22, 23, 24, 25

Griswold v. Connecticut, 381 U.S. 479 (1965) 15

H.L. v. Matheson, 450 U.S. 398 (1981) 17

Harris v. McRae, 448 U.S. 297 (1980) 17

Illinois State Board of Elections v. Socialist Workers Party, 440 U.S. 173 (1979) 23

Lochner v. New York, 198 U.S. 45 (1905) 7

Maher v. Roe, 432 U.S. 464 (1977). 6, 16

Mandel v. Bradley, 432 U.S. 173 (1977). 23, 25

Marbury v. Madison, 1 Cranch 137 (1803) 8

Martin v. Hunter's Lessee, 1 Wheat. 304 (1816) 9, 10, 11

Mobile v. Bolden, 446 U.S. 55 (1980) 17

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 16, 17, 19, 20, 22, 25 27

Roe v. Wade, 410 U.S. 113 (1973) . 4, 8, 14, 15, 16, 17, 18, 19, 20, 26, 27, 28

U.S. v. Nixon, 418 U.S. 683 (1974) . 9

Williamson v. Lee Optical Co., 348 U.S. 483 (1955) 6

Other Authorities

Akron Ordinance 160-1978 (Chapter 1870) 19, 24, 26

Hamilton, The Federalist, Nos. 45-49, 78. 8

Nos. 81-746 and 81-1172

In The
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Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners,

v.

City of Akron, et al.,
Defendants-Respondents

BRIEF AMICI CURIAE OF CALIFORNIA WOMEN LAWYERS AND THE WOMEN LAWYERS' ASSOCIATION OF LOS ANGELES

INTEREST OF AMICI

Amici organizations have been actively involved in legal issues which affect the

rights of all women and are committed to preserving freedom of reproductive choice. As bar associations, amici organizations are particularly sensitive to attempts to use the law to erode the rights of women. Accordingly, amici organizations seek to present the reasons they believe the challenged ordinances should be found unconstitutional.

CALIFORNIA WOMEN LAWYERS is a statewide bar association in California which advocates for and educates about the legal rights of women. As an umbrella organization, it represents the interest of approximately 10,000 women lawyers and its affiliates include eleven of the largest local women's bar associations in the state.

WOMEN LAWYERS' ASSOCIATION OF LOS ANGELES ("WLALA") is a county-wide bar association affiliated with the Los Angeles County Bar Association. Its members are

approximately 950 male and female lawyers, law students and judges who are concerned with the special problems affecting women in our society. The right of procreative choice is of unique concern to women. WLALA actively opposes all laws which attempt to abridge, limit or deny women's right to legal abortion.

Consent of the parties has been obtained for the submission of this brief by the undersigned amici curiae.

SUMMARY OF ARGUMENT

The principle that this Court is the ultimate arbiter of constitutional rights is a fundamental tenet of our system of government. To depart from this principle because of the emotional and political nature of abortion would gravely damage basic principles of the American constitutional system.

In Roe v. Wade and other cases involving fundamental rights, this Court has established that the appropriate standard of review is whether a challenged regulation is justified by a compelling state interest and whether the regulation is narrowly drawn to further that interest.

Application of the Roe v. Wade standard should result in this Court finding that the Akron restrictions cannot be justified by any compelling state interest and are overly broad.

ARGUMENT

I

The constitutionality of the challenged abortion regulations, as with all regulations affecting fundamental rights, should be determined by this Court, not state legislatures.

In its Brief Amicus Curiae for the United States, the Department of Justice argues that this Court should accord "significant weight" to the judgment of state legislatures in determining the constitutionality of abortion regulations. This argument is based upon the mistaken characterization of this issue as a policy determination. This Court does not make a policy choice in determining the constitutionality of a statute or ordinance. Rather, the determination is made by testing the questioned legislation against an objective, constitutional standard. Whether the tested regulation survives this scrutiny is not influenced by

considerations of policy. Laudatory regulations, as well as reprehensible ones, must pass the constitutional test when challenged.

Whether one segment of society believes a regulation is oppressive or exemplary is irrelevant to the determination of constitutionality. As this Court has declared, a determination that a particular regulation is or is not constitutional "is not based on a weighing of its wisdom or social desirability, for this Court does not strike down state laws 'because they may be unwise, improvident, or out of harmony with a particular school of thought.'" Maher v. Roe, 432 U.S. 464, 479 (1977), quoting Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955). The Court is frequently faced with issues on which reasonable people may differ, indeed, on which reasonable people passionately

disagree. Yet, as Justice Holmes pointed out in his often quoted dissenting opinion in Lochner v. New York:

> "[The Constitution] is made for people of fundamentally differing views, and the accident of our finding certain opinions natural and familiar or novel and even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States." 198 U.S. 45, 76 (1905).

Amici do not believe that the issues facing the Court in determining the constitutionality of the challenged abortion restrictions differ significantly from the issues to be settled in determining the constitutionality of any other regulation affecting fundamental rights. Unquestionably, many individuals hold widely different and passionately felt convictions regarding abortion. The issue has been the focus of a longstanding national debate. However, we believe that the passions and

controversy surrounding abortion have heightened since the Court acknowledged the "sensitive and emotional nature of the abortion controversy" and determined that its task was to "resolve the issue by constitutional measurement, free of emotion and of predilection." Roe v. Wade, 410 U.S. 113, 116 (1973).

The Justice Department, in its Amicus Brief, raises issues regarding judicial review that were the focus of intense debate at the time the United States Constitution was adopted, Hamilton, The Federalist, Nos. 45-49, 78, and which continued unabated well into the formative years of our Government. In an effort to resolve this controversy within the framework of the Constitution, Justice Marshall wrote several landmark decisions which established that "[i]t is emphatically the province and duty of the judicial department to say what the law is." Marbury v.

Madison, 1 Cranch 137, 177 (1803). See also, Fletcher v. Peck, 6 Cranch 87 (1810); Martin v. Hunter's Lessee, 1 Wheat. 304 (1816); Cohens v. Virginia, 6 Wheat. 264 (1821). In recent years, the Court has reaffirmed this vision of judicial authority in the strongest terms. U.S. v. Nixon, 418 U.S. 683, 705 (1974); Baker v. Carr, 369 U.S. 186, 211 (1962). As the Court declared in Cooper v. Aaron, "the basic principle that the federal judiciary is supreme in the exposition of the law of the Constitution . . . has ever since [Marbury] been respected by this Court and the Country as a permanent and indispensable feature of our constitutional system." 358 U.S. 1, 18 (1958).

In its Amicus Brief the Justice Department poses the question "[w]hich branch [i.e., judicial or legislative] should have a presumed preference in lawmaking authority in those areas that

might properly belong to either?" This is a misconception of the issues. The ultimate determination of constitutionality does not properly belong to either under our governmental system. It is a basic premise of constitutional law that this authority vests in the Courts. "The Courts of the United States can, without question, revise the proceedings of the executive and legislative authorities of the States, and if they are found to be contrary to the constitution, may declare them to be of no legal validity." Martin v. Hunter's Lessee, 1 Wheat. 304, 344 (1816).

The Justice Department further argues that individual persons are the best judges of which rights they deem "most fundamental" and that these individuals elect legislators to carry out their preferences, who then enact the public will into law. Therefore, according to this argument, legislative enactments must be regarded as

the supreme expression of the public will and may suffer no constitutional review. The implications arising from this argument are enormous and go to the very heart of our constitutional system. It is most astonishing to amici that this argument should be made on behalf of the United States. Yet again, Justice Story's words provide the most eloquent rebuttal to the Justice Department in declaring "the importance, and even necessity of uniformity of decisions throughout the whole United States, upon all subjects within the purview of the constitution . . . The constitution of the United States was designed for the common and equal benefit of all the people of the United States." Martin v. Hunter's Lessee, supra at 347-48.

The Constitution "is framed for ages to come, and is designed to approach immortality as nearly as human institutions can approach it." Cohens v. Virginia, supra at

387. It does not deal in individual preferences or decisions influenced by the pressures and fashions of the moment. A legislature must, by its nature, be responsive to temporary forces. Because the legislature is subject to removal by the political process, it is not the appropriate body to ultimately determine the constitutionality of any enactment.

Legislative determinations are entitled to "careful attention." Columbia Broadcasting System, Inc. v. Democratic National Committee, 412 U.S. 94, 103 (1973). But such attention does not constitute a deferral or render legislative actions immune from judicial scrutiny. Fullilove v. Klutznick, 448 U.S. 448, 473 (1980).

In determining the validity of the challenged abortion restrictions the issue is not whether the City of Akron should, as a matter of policy, regulate the performance of abortions or whether the means

chosen to regulate abortions are the most popular or appropriate ones, but rather, whether Akron has exercised its authority in a manner consistent with the United States Constitution.

II

Abortion regulations may be justified only by a compelling state interest and must be narrowly drawn.

The defendants, intervenors and the United States Justice Department, in its amicus curiae brief, inaccurately describe and distort the standard of review used by this Court in determining the constitutionality of regulations that restrict the abortion decision. They argue that any regulation of abortion is valid as long as it does not unduly burden a woman's decision to terminate her pregnancy. Not only is this view contrary to the standard established in Roe v. Wade, 410 U.S. 113 (1973), it is contrary to the standard applied by this Court in cases involving every other fundamental constitutional right.

In Eisenstadt v. Baird, 405 U.S. 438, 447 n.7 (1972) this Court set forth the appropriate form of analysis: "[I]f we

were to conclude that the Massachusetts statute impinges upon fundamental freedoms under Griswold [v. Connecticut, 381 U.S. 479 (1965)], the statutory classification would have to be not merely rationally related to a valid public purpose but necessary to the achievement of a compelling state interest." (emphasis in original). And in Dunn v. Blumstein, 405 U.S. 330, 337 (1972), this Court, in concluding that a durational residence requirement for voting was unconstitutional, declared the test to be "whether the exclusions are necessary to promote a compelling state interest."

This Court has consistently followed the standard established in Roe v. Wade, supra, which held that state interference or regulation that burdens the abortion decision is permissible only when the state has demonstrated a compelling interest justifying the regulation.

The Justice Department suggests that the Court has retreated from or limited the scope of Roe v. Wade. On the contrary, the Roe v. Wade standard was affirmed in Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), and has been followed in every abortion case reviewed by this Court since. For example, in Carey v. Population Services International, 431 U.S. 678, 688 (1977) this Court made it clear that state abortion regulations may be justified only by a compelling state interest and must be narrowly drawn to express only the legitimate state interests at stake. In Maher v. Roe, 432 U.S. 464, 475, this Court expressly states that its conclusion in that decision "signals no retreat from Roe or the cases applying it" and recognizes that "[t]here is a basic difference between direct state interference and state encouragement of an alternative activity." And again, in

Harris v. McRae, 448 U.S. 297, 312 (1980), this Court reaffirmed the Roe v. Wade standard by unequivocally stating that "if a law 'infinges upon a fundamental right . . . [it] is presumptively unconstitutional.'" (quoting Mobile v. Bolden, 446 U.S. 55, 76 (1980).)

Reliance on cases such as Bellotti I and II (Bellotti v. Baird, 428 U.S. 132 (1976); Bellotti v. Baird, 433 U.S. 662 (1977).), and H.L. v. Matheson, 450 U.S. 398 (1981), foster a distorted view of the appropriate standard of review in abortion cases. Amici believe that it is inappropriate to use these cases which dealt with the availability of abortions to minors as support for regulations limiting the availability of abortions to adult women. As this Court recognized in Danforth, supra, "the State has somewhat broader authority to regulate the activites of children than adults." 428 U.S. at 74.

Characterization of the appropriate standard of review as a "two-step analysis" or as an "unduly burdensome" test serves no purpose other than to cloud the issue before the Court. Regardless of how the appropriate standard is characterized, this Court has made it clear that, as with all other fundamental rights of privacy, state interference with the decision of a woman and her physician to terminate her pregnancy must be justified by a compelling state interest and any abortion regulation must be narrowly drawn to express that legitimate state interest.

Amici urge this Court to adhere to the standard of review established in Roe v. Wade and followed in the subsequent abortion decisions.

III

The Akron abortion regulations are not justified by a compelling state interest and are not narrowly drawn.

Amici urge this Court to adhere to the standard established in Roe v. Wade, supra, and subsequent abortion decisions, and find that the challenged abortion restrictions adopted by the City of Akron, Akron Ordinance 160-1978 (Chapter 1870), place an impermissible burden on the exercise of a fundamental privacy right and are not justified by a compelling state interest.

Application of this Court's ruling in Danforth, supra, to Akron's parental notice, parental consent, and second trimester mandatory hospitalization requirements, Chapters 1870.05 and 1870.03, should result in a finding of unconstitutionality.

This Court found that the consent requirements in Danforth effectively gave a person other than the patient and her

physician the right to veto an abortion decision. This was therefore contrary to Roe v. Wade which prohibits the state from exercising such a veto. The City of Akron's parental notification requirement is, similarly, impermissibly overbroad because it applies to both immature and mature, emancipated minors. See, Danforth, supra, and Bellotti II, supra.

The Akron mandatory hospitalization requirement's restrictive effect on a woman's abortion decision is no different from the restrictive effect of the regulation prohibiting saline amniocentesis as a method of abortion after the first twelve weeks of pregnancy that this Court found unconstitutional in Danforth.

In Danforth, the Court recognized the unavailability of safer alternative methods for terminating second trimester abortions and also acknowledged then current medical information that indicated that the saline

procedure was safer than childbirth. In view of this determination, the Court held the saline prohibition to be "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." 428 U.S. at 78. The regulation did not withstand constitutional scutiny because the state failed to demonstrate that it furthered the state's interests in protecting maternal health.

The Akron mandatory hospitalization requirement should, similarly, be found unconstitutional. The record before this Court indicates that the dilation and evacuation ("D & E") procedure is the safest method of performing post-first trimester abortions today and that its performance in outpatient facilities is widely accepted in the medical community. The record also indicates that second trimester D & E abortions are also much safer than

childbirth. Nevertheless, only two hospitals in Akron perform second trimester abortions.

This regulation is precisely the kind of intereference rejected by this Court in Danforth. It serves no compelling state interest in protecting maternal health and only inhibits the vast majority of post-first trimester abortions in Akron. Women seeking post-first trimester abortions in Akron are burdened with the markedly increased cost and longer time period required by hospitalization. The Sixth Circuit's decision, Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981), upholding the constitutionality of the "hospital only" requirement is clearly in conflict with this Court's decisions requiring abortion regulations to be narrowly drawn.

Furthermore, the Sixth Circuit's reliance on Gary-Northwest Indiana Women's

Services, Inc. v. Bowen, 421 F.Supp. 734 (N.D. Ind. 1976), aff'd 429 U.S. 1067 (1977), as authority for upholding the mandatory hospitalization requirement is misplaced for several reasons. 651 F.2d at 1208-10.

The Circuit Court was of the opinion that this Court's summary affirmance of Gary-Northwest precluded it from considering the "more detailed" evidence and constitutional considerations present in the Akron case. This Court has established that "the precedential effect of a summary affirmance can extend no further than 'the precise issues presented and necessarily decided by those actions.'" Illinois State Board of Elections v. Socialist Workers Party, 440 U.S. 173, 182 (1979) (quoting Mandel v. Bradley, 432 U.S. 173 (1977).) The precise issues presented and decided in the instant case are significantly different from those in Gary-Northwest.

First, the Akron statute differs significantly from the Indiana statute. The Indiana statute's definition of hospital includes ambulatory outpatient medical centers, thereby allowing second trimester abortions to be performed in a facility other than a hospital accredited by the Joint Commission on Accreditation of Hospitals. On the other hand, the Akron statute requires the hospital to be JCAH accredited. Akron Ordinance Section 1870.01(B). In this regard the Akron statute is more restrictive.

Second, the District Court's decision in Gary-Northwest was based in part on its finding of certain evidentiary failures. 496 F.Supp. at 903. Little evidence was presented concerning the impact of the Indiana statute on the availability of second trimester abortion services. This is precisely the kind of evidence that this

Court found to be of critical importance in Danforth, supra at 77-79.

There is no failure of proof in the present case. The Sixth Circuit recognized that the evidence before it was "more detailed" and "abundant" than that produced in Gary-Northwest. 651 F.2d at 1209-10. It should also have recognized that this distinction undercuts the precedential value of Gary-Northwest. Indeed, this Court has cautioned lower courts not to blindly follow summary affirmances, Fusari v. Steinberg, 419 U.S. 379 (1975), and not to rely too heavily on summary affirmances when the factual issues presented in the two cases are different, Mandel v. Bradley, supra.

Finally, it is important to note that there was a trial in this case and only a short hearing on a preliminary injunction in Gary-Northwest.

Turning to the remaining challenged provisions, it is clear that Akron Ordinance Sections 1870.06-.07 are violative of the Roe v. Wade standard. These ordinances, requiring that every woman seeking an abortion must be subjected to the reading of a medically inaccurate and biased "script" by the attending physician and must then wait 24 hours before the medical procedure can be performed, are a perversion of the useful and well-respected concept of informed consent. The mandatory disclosures do not provide the information necessary to weigh the medical risks attending abortion procedures, but are calculated to interfere with the process of rational decision-making. Not only do these requirements interfere with the exercise of the attending physician's best medical judgment, they also place unnecessary time, economic, and psychological burdens and pressures upon the woman who is

attempting to exercise her right of procreative choice. Such effects render these ordinances unconstitutional. Roe v. Wade, supra; Doe v. Bolton, 410 U.S. 179 (1973); Danforth, supra.

None of the Akron abortion restrictions are justified by any compelling state interest. In fact, the challenged restrictions are an unwarranted governmental intrusion into a fundamental personal liberty. The ordinances are therefore unconstitutional.

IV

CONCLUSION

In sum, amici believe that this Court is the appropriate body to determine the constitutionality of abortion regulations and in doing so should apply the standard set forth in Roe v. Wade. The Akron ordinances restricting abortion fail to meet this standard and should therefore be declared unconstitutional.

For the foregoing reasons amici respectfully submit that the judgment of the Sixth Circuit Court of Appeals be affirmed in all respects except for the holding that its finding that the mandatory

hospitalization requirement is constitutional.

Respectfully submitted,

Susan Lerner
One Wilshire Boulevard
Suite 1600
Los Angeles, California 90017

Sherri M. Kirk
261 South Figueroa Street
Suite 210
Los Angeles, California 90012

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IN THE

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No. 81-746

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Petitioners,

— v. —

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,
Respondents.

No. 81-1172

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,
Petitioners,

— v. —

CITY OF AKRON, *et al.*
and
FRANCOIS SEGUIN, M.D., *et. al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF AMICUS CURIAE OF THE CATHOLIC LEAGUE FOR RELIGIOUS AND CIVIL RIGHTS IN SUPPORT OF THE PETITIONER IN NO. 81-746 AND THE RESPONDENTS IN NO. 81-1172

CHARLES E. RICE
Notre Dame Law School
University of Notre Dame
Notre Dame, Indiana 46556
(219) 239-5667

Counsel of Record for Amicus Curiae

THOMAS PATRICK MONAGHAN
Catholic League for Religious and Civil Rights
1100 West Wells Street
Milwaukee, Wisconsin 53233
(414) 289-0170

Attorney for Amicus Curiae

TABLE OF CONTENTS

Page(s)

INTERESTS OF THE AMICUS CURIAE 1

SUMMARY OF ARGUMENT 1

ARGUMENT 2

I. Legal Provision for the Humane Disposal of Aborted Human Remains is Constitutional . . . 2

II. A Humane Disposal Statute Related To Aborted Human Remains is a Legitimate Matter of Legislative Judgment 17

CONCLUSION 29

TABLE OF AUTHORITIES

Cases Cited	Page(s)
Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1211 (6th Cir. 1981)	2,3
Beal v. Doe, 432 U.S. 438, 462-63 (1977)	19,20,21,22,23,25,26
Colautti v. Franklin, 439 U.S. 379 (1979)	2
Dred Scott v. Sandford, 60 U.S. (19 How.) 393 (1857)	5
Feminist Women's Health Center, Duncan Donovan, Atheists United v. John Van de Camp, No. 413606, Los Angeles Superior Court (June 29, 1982)	16
Ferguson v. Skrupa, 372 U.S. 726, 731-32 (1963)	17,21
Floyd v. Anders, 440 F. Supp. 535 (D.S.C. 1977)	7
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INTERESTS OF THE AMICUS CURIAE

The Catholic League for Religious and Civil Rights is a non-profit voluntary association, national in membership, organized to promote goodwill and harmonious relations in the community, to combat all forms of religious prejudice and discrimination and to defend the human rights and sanctity of each human life.

SUMMARY OF ARGUMENT

I. *The Abortion Cases* cannot and do not preclude the legislature from making a value judgment as to the dignity of each human life regardless of whether the life is discarded. The nature of the act of abortion, the consequent loss of a human life and the intrinsic value of each human life, may be recognized by the legislature and appropriate statutory provisions enacted providing for the humane disposal of aborted human remains.

II. Because of the devastating impact on minorities disproportionate to the rest of the population of the presen abortion policy, and the erroneous factual and legal base of the *Roe* v. *Wade* decision, *Roe* v. *Wade* and its progeny are not sound enough to be relied upon under any theory of "substantive due process" to deny the legitimacy of a reasonable, legislative response to the problem of the humane disposal of aborted human remains.

ARGUMENT

I. Legal Provision for the Humane Disposal of Aborted Human Remains is Constitutional.

The Sixth Circuit in *Akron Center for Reproductive Health, Inc. v. City of Akron*, 651 F.2d 1198, 1211 (6th Cir. 1981), struck down § 1870.16 of the Akron Ordinance requiring that "Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a humane and sanitary manner," as void for vagueness.

Arguably, expecting an elemental understanding of "humane" by abortion providers or "abortionists," *Colautti v. Franklin*, 439 U.S. 379 (1979) (White, J., Burger, C.J., Rehnquist, J., dissenting at 403, 408, 409), may be too much to base criminal sanctions on, particularly given the inhumane aspects of the abortion profession. B. Nathanson, M.D., *Aborting America*, 97-145 (1979); Kaltneider, et al, *The Impact of Mid-trimester Abortion Techniques on Patients and Staff*, Am. J. Orthopsychiatry, July 1971 at 620-626. Given the mind-set addressed, more specificity may be required in such an ordinance than might be required in common human understanding. While there are certain problems in requesting and trusting one who is an abortion provider to understand and comply with treating a human fetus, just aseptically terminated by him, in a humane manner, i.e., a manner "marked by compassion, sympathy, or consideration for other human

beings or animals," *Webster's Third New International Dictionary* 1100 (1965), any ruling should make clear that the state may recognize the value of those human beings at the stage of development they are.

However, in striking down the "humane disposal" provision on the grounds of "vagueness," the Sixth Circuit indicates that an essential basis of the ruling was the court's objection "to mandat[ing] some sort of 'decent burial' of an embryo at the earliest stages of formation." *Akron Center*, 651 F.2d at 1211. Such language impliedly aligns the Sixth Circuit with the district court in *Margaret S. v. Edwards*, 488 F. Supp. 181, 222 (E.D. La. 1980), which explicitly held that humane disposal provisions were unconstitutional because they recognized a value in the human fetus.

Two issues are presented by § 1870.16 of the Akron Ordinance.

First, there is the standard question of "vagueness," interestingly stated in that abortionists are asked to humanely dispose of their target.

Secondly, there is the hidden issue addressed clearly in *Edwards*, and by implication in the Akron decision now before the Court that the "right" constructed in *Roe v. Wade*, 410 U.S. 113 (1973) constitutionally precludes the state from recognizing value in the human embryo or human fetus and in making any statement of that value judgment.

This is the issue as to humane disposal addressed in this brief by the amicus to the Court.

In *Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980) the court acknowledged that the state may regulate the disposal of a dead fetus, but held the

involvement of the woman in the process unduly burdened her decision.

The humane disposal provisions of the statutes in *Edwards* and in *Leigh* differ distinctly from those in the Akron Ordinance in that the woman is not involved in the humane disposal decision under the Akron Ordinance. Therefore, the ordinance clearly does not interfere at all with the woman's decision whether to terminate her pregnancy -- making it unnecessary to assess whether such potential interference would be "unduly burdensome." *Maher* v. *Roe*, 432 U.S. 464, 474 (1977).

A review of the underlying and unspoken presupposition of the newly constructed abortion liberty that human life before birth is valueless and legally nonexistent will illustrate how humane disposal of the fetus or embryo sums up the continuing confrontation over abortion in our society, a clash which will continue to exacerbate as long as judicial involvement remains prominent.

* * *

"We need not resolve the difficult question of when life begins." *Roe* v. *Wade*, 410 U.S. at 159.

"The lie is the specific evil which man has introduced into nature. . . . The lie is our very own invention, different in kind from every deceit that the animals can produce." Martin Buber, quoted in Rosenblum, *Coercion in Liberation's Guise*, in Abortion and Social Justice 143, 146 (Hilgers, Horan eds. 1972).

Physicians, biologists, and other scientists agree that conception marks the beginning of the life of a human being -- of a being that is alive and is a member of the human species. There is overwhelming agreement on this point in countless medical, biological, and scientific writings. Extensive quotation from such writings would be unnecessarily redundant except for the strenuous efforts by some parties to deny or to obscure this basic fact. . . . If the United States government is to give reasonable consideration to the abortion issue it must start from the fact that unborn children are human beings. . . . No governmental body that approaches the abortion question with honesty can accept semantic gymnastics that obscure the real issue. Any suggestion that some human beings can be 'nonpersons' under the law simply echoes the holding of *Dred Scott v. Sandford*, 60 U.S. (19 How.) 393 (1857), a decision the fourteenth amendment was intended to reverse. Senate Committee on the Judiciary, *The Human Life Bill* -- S. 158, S. Rep. No. J-97-16, 97th Cong., 1st Sess. 7, 13, 24 (1981).

It is worth noting that of all the twenty-two expert witnesses who testified before the Senate Subcommittee on the Separation of Powers . . . on the medical and biological questions, none ever claimed that unborn children are not alive nor that they belonged

> to any other species than human, or even that they were part of the mother rather than a distinct individual human being. . . . Wasn't the significance of the birth of Louise Brown that her conception was in a test tube? Hyde, *The Human Life Bill* Spring 1982 The Human Life Review, 6 at 7, 10.

Then, on January 11, 1982, Newsweek magazine showed a picture of an eight week old human embryo on its cover entitled, "How Life Begins" and announced, in the mass media market, *despite* the "difficult question of when life begins," *Roe v. Wade*, 410 U.S. at 159, that *human life begins at conception.*

> If newborns could remember and speak, they would emerge from the womb carrying tales as wondrous as Homer's. They would describe the fury of conception and the sinuous choreography of nerve cells, billions of them dancing pas de deux to make connections that infuse mere matter with consciousness. They would recount how the amorphous glob of an arm bud grows into the fine structure of fingers agile enough to play a polonaise. They would tell of cells swarming out the nascent spinal cord to colonize far reaches of the embryo, helping to form face, head and glands. The explosion of such complexity and order -- a heart that beats, legs that run and a brain powerful enough to contemplate its own origin -- seems like a miracle. It is as if a single

dab of white paint turned into the multi-colored splendor of the Sistine ceiling. *How Human Life Begins*, Newsweek, Jan. 11, 1982, at 38.

Still, the unborn child, who in Dean Prosser's words is as much a person in the path of an automobile as his mother, is declared non-existent before the abortionist's scalpel and fee. *Floyd v. Anders*, 440 F. Supp. 535 (D.S.C. 1977). He is spoken of as a child by the government on posters in liquor stores warning that alcohol may be hazardous and in appeals from the March of Dimes, "Take care of your baby before he is born." Yet this amorphous blob of paint that becomes the "multicolored splendor of the Sistine ceiling" is not a person before the law, while General Motors is.

Such an anomaly will not long last, for we will not begin to ask pregnant women "How's your fetus?" any more than we will come to feel a poetic bonding to General Motors as person to person.

We know. The whole world knows. All creation knows.

This is *why* the question of "humane disposal" raises hackles -- because it forces a confrontation with the act itself. (*See* President's letter, *infra*, p. 15.) What is it that we are doing and what is this embryo -- blob -- tissue or whatever? We cannot in one breath recognize it as a blob of paint turning into the "multicolored splendor of the Sistine ceiling" and in another, chuck it in a waste disposal. It is something -- a fact we do not care to admit, particularly when we go to kill.

As a point of constitutional right one might certainly state that each of us has a constitutional right to lie to himself. The law does not require one convicted to personally admit that he acted wrongly. Likewise, the fact that a woman contemplating abortion internally knows it is the taking of human life does not mean that she should externally acknowledge the action. *See* Senate Committee on the Judiciary, *The Human Life Federalism Amendment* S.J. Res. 110, S. Rep. No. 465, 97th Cong., 2d Sess. 42, 50 (1982) and polls cited therein.

However, it should be clear that though an individual may have a right to lie to himself, there is no right attached to any individual to demand that society at large give public acceptance to that lie. Those who wish to avail themselves of the abortion liberty have no right to demand that the rest of us deny what they are doing, or that the rest of us act as if nothing were occurring. Such a view of the abortion liberty would certainly be overstated and patently inaccurate as to the fact of killing that is occurring. It would articulate an apocalyptic commitment to abortion that is almost mystical.

Indeed the opposition of the abortion providers to humane disposal raises a question of their own comfortableness with the materialistic philosophy. Jancin, *Emotional Turmoil of Physicians, Staff Held Biggest D & E Problem*, Ob. Gyn. News, Dec. 15, 1981, at 1, 16. If "it" really is a blob, a speck of flesh, a hank of hair, "potential anything" and nothing more, why care how it is disposed of? If someone wished to

wished to pass a statute for the humane disposal of appendixes, so what?

In their opposition to the provision of humane disposal for the "abortus," the "conceptus," the blob, are the abortion providers showing a desire that the public assuage their own consciences? If so, they are perhaps better than their actions.

Then again, they may be truly committed to infecting all with their evil — to wringing from each a statement that each human life has no intrinsic worth -- an *auto de fe* for the Secularist Creed, prior to the aseptic and clinical incineration of varying classes of life. However, in the twentieth century's scientific orthodoxy of "man is the measure of all things," an act of obeisance to the lie will not save you, but damn you.

The true target of those oppposed to the "humane disposal" concept is not what is done with the human "material" but that the human soul be attacked.

What about our soul?

Yes, that is what is written -- soul.

In the positivistic legal world it is a taboo to mention "it" as well -- somehow unbecoming in a brief to a court. The established orthodoxy demands that we act as though there were no God (an empirically absurd position) and that we have no soul.

While scientists ponder the Shroud of Turin or the heavens for proof, R. Jastrow, God and the Astronomers (1978), the shocking evidence of our spiritual nature bursts forth in the scientific twentieth century's testimony of Auschwitz, the Gulag, Cambodia, and Nagasaki. And once we admit that recognition of evil demanded by

the events of this century, we know *God is* and *we are* -- and we know the stakes of the conflict.

As Elie Wiesel heard intuitively on entering a concentration camp as a prisoner: "The soul is important and the enemy knows it; that's why he tries to corrupt it before destroying us. Do not let him." E. Wiesel, One Generation After, 79-80 (1970).

By their public positions against humane disposal, abortion providers show how they internalize the knowledge of killing. In accepting the responsibility of killing, the abortion advocate is driven by a dynamic much like the slaveholders of old. Slavery was once apologetically defended as a "necessary evil." Its actual evil nature compelled it to advocate itself as a "positive good."

Similarly, as with slavery, we have watched abortion move from being a drastic measure, a last resort, a necessary evil, an unfortunate occurrence -- to being "a fundamental right" upon which a vast industry of death is built. The term "abortion choice" becomes layered with a nonsensical attitude as though it is something that everyone should have along with the chicken in every pot and the car in every garage. The seeds of its own undoing are thus laid.

> Since the old ethic has not yet been fully displaced it has been necessary *to separate the idea of abortion from the idea of killing*, which continues to be socially abhorrent. The result has been a curious avoidance of the scientific fact, which everyone really knows, that human life begins at conception and is

> continuous whether intra- or extra-uterine until death. The very considerable semantic gymnastics which are required to rationalize abortion as anything but taking a human life would be ludicrous if they were not often put forth under *socially impeccable auspices. A New Ethic for Medicine and Society*, 113 California Medicine 67, 68 (1970). (emphasis added)

In *Edwards*, 488 F. Supp. 181, the attempt to separate "the idea of abortion from the idea of killing" is carried through under the "socially impeccable auspices" of the federal judiciary. However, due to the remaining stature of the judicial role which has not been completely depleted, the "socially impeccable auspices" of a court accentuates the "ludicrous" nature of the rationalization.

> Such a question (burial or cremation) *equates the abortion process with the taking of a human life*, because fetal remains are required to undergo the same *elaborate formalities* of burial or cremation which are traditionally reserved for deceased persons. *Id.* at 222. (emphasis added)

Not only are we told that abortion is not killing, but now we are told that a funeral, the grieving process for the living, the recognition of the value of the person and the intrinsic worth of the human made in the image of God -- all this is nothing but an "elaborate

formality." What then, does this mean: that a human body with no remaining human contacts may be cast away as a crumpled Dixie Cup?

We began by denying we knew when life begins; we then denied the fetus is a person; then we denied "it" was a human being; and then, not only in the face of God did we deny its humanity (for who cares of such blasphemy in this century of Progress), but in the face of the findings of the Ethics Advisory Board (a regulatory agency of the United States government itself — perhaps even a "person" under the law?), we even deny "it" the "profound respect" to which the *Report of the Ethics Advisory Board on HEW Support of Research Involving Human In Vitro Fertilization and Embryo Transfer*, 44 Fed. Reg. 35033, 35056 (June 18, 1979) says "it" is "entitled".

We began by denying humane disposal to "it" and now we mock such disposal of ourselves as "elaborate formalities." In following this trend we need not fear such "elaborate formality" will continue to be "traditionally reserved" for any of us, for after all, there are careers to pursue, cases to be argued and decided, and "getting and spending." We shall "let the dead bury the dead," not because we are concerned with eternal life, but because we no longer believe in it at all, or even life here and now or anything.

"Since the fetus is not a person, neither is it a human being," *Edwards*, 488 F. Supp. at 222. The statement enshrined in the West Reporter leaps from the pages, and unless one is either stupid or evil it can only be read with tears or hilarity. Tears for when the reader feels and laughter when he thinks.

Not content with the foolishness inherent in once saying a human fetus is not a human being, the court says it again by criticizing the humane disposal statute for "impermissibly" raising "the status of a fetus to that of a human being by using language equating fetal remains with human remains . . ." *Id.*

Observe how the court uses "fetus" as a noun *unmodified*, in contrast to "being" as a noun modified by "human".

The question to be asked is what kind of fetus? — if it is a variety of animal fetus then certainly such a fetus can't be raised to the level of a human being or lowered thereto.

Because these are humans, however, who are obtaining abortions, their fetuses are human and no statute does or can raise them to the level of human beings because by all definitions a *human* fetus is a *human* being. A dog fetus is a *dog* being. A *cow* fetus is a *cow* being. A *horse* fetus is a *horse* being. The principle is rather consistent.

Observe again how the sentence then uses "remains" as a noun modified by "fetal" to contrast with "remains" modified by "human", as if there were some natural opposition between the two. What kind of "fetal" is opposed to "human"? Certainly not a "human fetus" or a "fetal human". If the subject matter for disposal is a human fetus, then the remains are fetal *and* human. The remains can't be fetal *or* human -- they are either human or non-human, fetal or non-fetal. Human and fetal are not mutually exclusive words.

The verbiage of *Edwards*, competes with Judge Clement Haynsworth's statement in *Floyd v. Anders*, 440 F. Supp. at 539, that ". . . the Supreme Court declared the fetus in the womb is neither alive nor a person within the meaning of the fourteenth amendment."

Overlooking for a moment the jurisdictional requirement, if it were true that the unborn were not alive, the alleged need for abortions under any theory would be obviated. In fact everything would be obviated.

Does human language have to be aborted along with the human fetus?

> If the factual concepts on which legal decisions are based are mandatorily defined in ways which can support only the results reached, the possibility of reasoned public criticism is eliminated. Professor Richard Stith, Valparaiso University School of Law, quoted in S. Rep. No. 465, *supra* at 47.

Recently in Corpus Christi, Texas, two legally aborted fetuses discovered in a garbage dump were released by authorities for burial. Just as a nation honors her dead abroad and seeks them out whether they be missing in a Southeast Asian jungle or victims of fashionable leftist quackery in San Francisco and South America, so does the continued spectacle of the aborted unborn require us to act in a fitting and proper manner toward the dead.

On May 5, 1982 President Reagan gave public recognition to 17,000 dead kept in containers, labeled in

jars, found in Los Angeles when a storage container broke open. In a letter to a Dr. Philip B. Dreisbach the President stated:

> I have received your letter and I want you to know of the great horror and sadness evoked by the incident you described. When all is said and done, being confronted with the reality of abortion and its consequences removes all trace of doubt and hesitation. The terrible irony about this sudden discovery is not that so many human lives were legally aborted, but that they are only a tiny proportion of the 1.5 million unborn children quietly destroyed in our nation each year. This is the truth many would rather not face.
>
> Your decision to hold a memorial service for these children is most fitting and proper. On such an occasion, we must strengthen our resolve to end this national tragedy. I am hopeful that evidence like that found in California will move those who have thus far preferred silence or inaction and encourage them to agree that something must be done. I have expressed my anticipation that Congress act expeditiously on this matter and approve a measure which will remove this evil, and all its vestiges, from our society.
>
> Thank you for writing, and may God bless you in all your efforts.

In this same instance, a judge on June 29, 1982 issued a preliminary injunction restraining Los Angeles County from releasing "fetal tissue" for burial, pending trial, as plaintiffs "will suffer severe and irreparable injury." *Feminist Women's Health Center, Duncan Donovan, Atheists United, v. John Van de Camp*, No. 413606, Los Angeles Superior Court (June 29, 1982).

The acts of the officials remain on record and there can be no doubt of the emerging consensus. The people as human beings will recognize the intrinsic worth of the *human* as did the President.

If we are "a deeply religious people," *Zorach v. Clausen*, 343 U.S. 306 (1952) and a "society that . . . strongly affirms the sanctity of life," *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring) surely individuals should at least be able to have a memorial service without necessitating first the removal or consideration of a preliminary injunction.

The view that humane disposal provisions are unconstitutional because they recognize a value in the human fetus "misconceive[s] the nature and scope" *Maher*, 432 U.S. at 471, of the judge-made right in *Roe v. Wade*. This Court has not yet held that the State must regard and treat the human fetus by public proclamation or indifference as utterly lacking in human aspect or dignity.

Nothing in the Constitution or in the decisions of this Court thus far forbids a state's recognition of the fact that the human fetus is human life or forbids a state to act on that view except *to the extent* that

its acts might "override the rights of the pregnant woman that are at stake." *Roe v. Wade*, 410 U.S. at 162. Presumably those rights of the woman at this time are to terminate pregnancy prior to term, and *not* to demand that society financially underwrite her decision *Harris v. McRae*, 448 U.S. 297 (1980); or applaud by pretending "the human embryo" is not "entitled to profound respect" as the *Report of the Ethics Advisory Board, supra* at 35056 concluded "it" was. The newly claimed "right" "implies no limitation on the authority of a State to make a value judgement." *Maher*, 432 U.S. at 474.

II. A Humane Disposal Statute Related To Aborted Human Remains is a Legitimate Matter of Legislative Judgment.

In *Ferguson v. Skrupa*, 372 U.S. 726, 731-32 (1963) it was hoped this Court had buried the discredited doctrines of "substantive due process" of *Lochner v. New York*, 198 U.S. 45 (1905) by which "the Court, and not the legislature became the final judge of what might be law . . ." R. Jackson, The Struggle for Judicial Supremacy 70 (1931).

In *Ferguson*, 372 U.S. at 731-732, the Court said:

> We refuse to sit as a "super-legislature to weigh the wisdom of legislation," and we emphatically refuse to go back to the time when courts used the Due Process Clause "to

> strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a peculiar school of thought."

However, "substantive due process" apparently retained "potential life," for in *Roe v. Wade* and its progeny, "substantive due process," with the Court as a "super-legislature to weigh the wisdom of legislation," came back with a vengeance, striking down abortion laws "out of harmony with a peculiar school of thought." *Id.*

John Hart Ely, in *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L. J. 920, 935 (1973), observes that the Court manufactured a "super-protected" right "not inferable from the language of the Constitution" and then afforded the improvident and extravagant liberty "more stringent" protection than "the present Court accords the freedom of the press explicitly guaranteed by the First Amendment."

> While I would hesitate to argue that one *(Roe* or *Lochner)* is more defensible than the other in terms of judicial style, there *are* differences in that regard that suggest *Roe* may turn out to be the more dangerous precedent." *Id.* at 940.

"More dangerous" because the "fundamental right" fiction attempts to insulate the claim from rationality tests and requirements.

The actions of the Court in reviving "substantive due process" have impressed upon a whole people and vulnerable minorities the Court's "concepts of the socially desirable, the publicly acceptable, and the morally sound, with a touch of the devil-take-the-hindmost." *Beal v. Doe*, 432 U.S. 438, 462-63 (1977) (Blackmun, J., dissenting).

Polls show black people to be more strongly against abortion than other groups. Senate Judiciary Committee Report, No. 465, *supra* at 48; *Black Stand on Abortion*, New York Daily News, March 12, 1978, yet from their number come the most abortions in a stunningly disproportionate ratio.

Could subtle coercion and upper class manipulation of racial and sexual self-hatred be a factor in the contrast between the level of opposition to abortion and the level of utilization of abortion?

"Non-white women obtain abortions at nearly double the rate of whites . . ." *McRae*, 448 U.S. at 343 (Marshall, J., dissenting). Citing this, the dissent then called for "more searching judicial inquiry" along lines of an *impact* test so as to mandate funds for abortion on the grounds of discrimination!

Others observing this disproportionate rate of abortion among non-whites have wondered too -- not about alleged discrimination in *not* financing the killing off of a generation, but at the obvious discrimination in *financing* such a program, the net *impact* and *result* of which is the elimination of the minority -- admittedly by subtle coercion and democratic selection, but still the *impact* and *result* exposes the program for its inherent racism. Novak, *How*

Placidly They Accept Aborting So Many Black Babies (November 14, 1976) *reprinted* in Spring 1978 The Human Life Review 95.

The black population ". . . suffers a disproportionate share of the psychological effects of abortion upon mothers and upon other children." *Id. See also,* Freeman and Graves, *Risk of premature delivery among indigent Negro women based on past reproductive performance,* Obstet. Gynecol. 34: 648 (1969); Iffy, *Perinatal Statistics: The Effect Internationally of Liberalized Abortion,* in Hilgers, Horan, and Mall, New Perspectives on Human Abortion, 92-127, at 118, 119 (1981).

The evidence increases of this "brutal effect." *Beal,* 432 U.S. at 460 (Marshall, J., dissenting). Surely, "at some point a showing that state action has a devastating impact on the lives of minority racial groups must be relevant." *Jefferson* v. *Hackney,* 406 U.S. 535, 558, 575-576 (1972) (Marshall., J. dissenting).

> Black women are being aborted at a rate 2.5 times greater than any other ethnic group in New York City. Why? They are not being given the freedom to say no! They are being coerced into destroying their children! This must come to an immediate halt! Then, an investigation should be carried out, and those responsible should be brought to trial for one of the most ghastly crimes of this century. Erma Clardy Craven, *Abortion, Poverty and*

Black Genocide: Gifts to the Poor? Abortion and Social Justice, *supra* at 240.

". . . there truly is 'another world' 'out there', the existence of which the Court, I suspect, either chooses to ignore or fears to recognize . . ." *McRae*, 448 U.S. at 348, citing *Beal*, 432 U.S. at 463 (Blackmun, J., dissenting).

It is time the world "out there" of welfare coercion, of those enslaved in a new urban plantation system be recognized for what it is. And those afraid to recognize it for what it is are its administrators and their governmental supporters, whose power and influence depend on a continuing and self-perpetuating caseload without regard to human cost.

Under National Socialism abortion was promoted for Jewish and East European women only, not German women. William C. Brennan, *Medical Holocaust: Exterminative Medicine in Nazi Germany and Contemporary America*, Vol. I, 79, 80, 99, 124, 135 (1981). Governments, classes and cliques provide abortion as social policy for those for whom they do not care. The real world "out there" and "in here" is relentless in its vicious destruction, in the name of compassion and progress.

Abortion for "penniless pregnant women," *Beal*, 432 U.S. at 454 (Brennan, J., dissenting) is the epitome of "ethical bankruptcy". *Id.* at 456 (Marshall, J., dissenting).

The "peculiar school of thought" *Ferguson*, 372 U.S. at 732, requiring "a troubling journey into the realm of substantive due process," *Scheinberg* v. *Smith*, 659

F.2d 476, 484 (5th Cir. 1981) trots out many themes -- welfare costs, poverty and child abuse, health and privacy, among others. These legislative policy arguments must be examined so that the basic nature of the humane disposal question not be similarly misconstrued by increased court involvement on the authority of *Roe v. Wade*, a case with such an inadequate base in law and fact that in time it will be disavowed.

It has been argued in governmental bodies legislative and judicial that there should be a pro-abortion policy because of "the welfare costs that will burden the state for the new indigents and their support in the long, long years ahead . . . And so the cancer of poverty will continue to grow." *Beal*, 432 U.S. at 463 (Blackmun, J., dissenting).

This cost-benefit analysis is mirrored well in Problem 95 in a mathematics textbook in use in Germany in the 1930's:

> Problem 95. The construction of an insane asylum required six million RM. How many new housing units at 15,000 RM each could have been built for this sum? Adolf Dorner, Mathematik en Diensteder Nationalpolitischen Erziehung (1935).

There are unanticipated consequences to such an attitude, as the West German Court noted in finding an abortion statute unconstitutional. That court stated that its ruling could "be understood only in light of the historical experience and the spiritual-moral confrontation with the previous system of National

Socialism." Jonas and Gorby, *The West German Abortion Decision: A Contrast to Roe v. Wade*, 9 J. Mar. J. of Prac. and Proc. 605, 662 (1976). *See also* J. Burtchaell, *Die Buben sind unser Ungluck! The Holocaust and 'Abortion,'* in Rachel Weeping and Other Essays on Abortion, 141 (1982).

The dangers of the unwanted child and child abuse have been put forth. "The unwanted minority and mixed race children now spend blighted lives . . . ," *Beal*, 432 U.S. at 456 (Marshall, J., dissenting) and "absent day care facilities" they force their mothers "into full time child care." *Id.* at 458.

In order to justify abortion on such grounds, as "absent day care facilities," one must totally separate oneself from reality and judge *potential* and imagined violence or deprivation to a child later in life as more real than the real flesh and blood violence which ends the child's life, and the actual psychological violence which hounds the woman and her surviving children in later years. Calef, *The Hostility of Parents to Children: Some Notes on Infertility, Child Abuse and Abortions*, 1 Intl. Journ. of Psychoanalytic Psychotherapy 79 (1972). The policy in time will give way to cruelty and come readily to consent to the removal of the original object of concern -- the poor themselves.

The data seem to indicate that abortion exacerbated problems of child abuse by destroying the bonding process between mother and infant and in other ways. Ney, *Is elective abortion a cause of child abuse?* 4 Sexual Medicine Today 31 (June 1980); Ney, *Relationship*

between Abortion and Child Abuse 24 Can. Journ. of Psychiatry 620 (1980).

The devaluing of the child *in utero* is increasing psychological and physical problems for all, mothers and children. Kent, *Emotional Sequelae of Therapeutic Abortion: A Comparative Study*, 20 Brit. Colum. Med. Journ. 118 (1978); Kumar and Robson, *Previous Induced Abortion and Antenatal Depression in Primiparae*, 8 Psychological Medicine (1978).

"While suicide . . . is not unknown as a reaction to abortion, it is almost unknown among pregnant women and even among new unmarried mothers." S. Rep. No. 465, *supra* at 43. Contrast the actual empirical data with the assertion in *McRae*, 448 U.S. at 340 (Marshall, J., dissenting) that the result of no abortion funding "may be suicide." *See also* Tishler, *Adolescent Suicide Attempts Following Elective Abortion: A Special Case of Anniversary*, 1981 Pediatrics 670.

The indications are that where abortion is widespread, infant mortality is increasing and higher than in those areas where normal, natural childbirth is the rule. For example, Washington D.C. has the highest repeat abortion rate in the country, S. Rep. No. 465, *supra*, and *City Infant Mortality Rate Rises*, The Washington Post, June 19, 1981. *See also* Levin, *Association of Induced Abortion with Subsequent Pregnancy Loss*, June 27, 1980, J. A. M. A., 2495; Iffy, *Perinatal Statistics: The Effect Internationally of Liberalized Abortion*, New Perspectives, *supra* at 92-127.

A study by Thomas W. Hilgers, M.D. and Dennis O'Hare, *Abortion Related Maternal Mortality: An*

> . . . It is a bit like saying 'stock fraud and speculation in stocks, when stripped of the sensitive moral arguments surrounding them, are simply two alternative financial methods of dealing in the stock market.' When moral sensitivities are eliminated how do you distinguish good procedures from bad? . . . Is this so far from writing, 'Life is unquestionably a condition requiring medical services . . . Treatment for the condition may involve medical procedures for its termination or its continued support? 'Certainly the bland equation of life or death as two alternative and acceptable outcomes is shocking to the least tender conscience. Noonan, *A Half Step Forward: The Justices Retreat on Abortion,* Fall 1977 The Human Life Review, 11, 12, 16.

However, in the deliberately chosen starvation of the Bloomington baby, Infant Doe, the ". . . lawyer concocted an Orwellian euphemism for this refusal of potentially life-saving treatment -- 'treatment to do nothing.' " Will, *The Killing Will Not Stop,* The Washington Post, April 22, 1982, at A29, col. 3.

But stripped of the changing social engineering justifications of that "another world out there," *Beal* 432 U.S. at 463 (Blackmun, J., dissenting), there is an assertion of privacy as the basis of this judge-made right.

Legal commentators, regardless of their position on abortion, quickly pointed out the flimsy nature of

In-Depth Analysis, New Perspectives, *supra* at 90 has found that "natural pregnancy was found to be safer in both the first and second 20 weeks of pregnancy" than legal abortion. Contrast this actual empirical data of 1981 with the 1973 assertion of "the now established medical fact of safety" of abortion over natural pregnancy, *Roe v. Wade*, 410 U.S. at 163.

John Cardinal Newman writes about a hidden danger in an excessive reading of novels -- the habitual arousing of noble impulses to action with no real object or healthy outlet. In this way, an individual jaundices himself by experiencing emotional heights and depths without needing to involve himself in mental judgment or commitment or action. Right feeling never comes to inform right action. Thus the individual concerns himself with whether he has *feelings* of pity, righteous anger and charity, rather than whether he allows his feelings to inform *moral acts*.

Three of the dissenting opinions in *McRae*, 448 U.S. at 329 (Brennan, J., Marshall, J., and Blackmun, J., dissenting) are replete with such proper feelings, yet the morality of the act of abortion is avoided.

Indeed one is treated again to: "Abortion and child birth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy . . ." *McRae*, 448 U.S. at 332-333 (Brennan, J., dissenting; quoting *Beal*, 432 U.S. at 449.)

Professor John Noonan has noted, of this repeated statement:

a *privacy* rationale. J. O'Meara, in *Abortion: The Court Decides a Non-Case*, 1974 Supreme Court Review 337, 340, wrote, "there is nothing private about an abortion" and Ely, *supra*, at 932, observed that the detriments of pregnancy cited by the Court have "nothing to do with privacy in the Bill of Rights or any other sense the Constitution suggests."

The commentators, however, overlook the underlying logic of the *privacy* rationale, given the nature of the *act* of abortion. It is understandable that *privacy* be proclaimed as its basis, for *privacy* is a "peculiar school of thought" for such an act.

> . . . of all human pursuits murder has the most deadly need of privacy; . . . man will go to almost any lengths to preserve the solitude in which he evacuates or makes love but he will go to any length for that in which he takes life, even to homicide, yet by no act can he more completely and irrevocably destroy it . . ." W. Faulkner, *Intruder in the Dust* 57 (1948).

The foregoing experiences with judicial legislating on unsound theory should be kept in mind before answering the questions posed by what to do with the remains of aborted human beings.

Can the elected legislature make provisions for the humane disposal of aborted human remains? Can the elected legislature prevent the use of aborted human remains for experimentation or in the manufacture of cosmetics? Thimmesch, *Our grisly human fetal indus-*

try, Victoria Advocate, Dec. 18, 1981. Can trafficking in aborted human remains be prohibited? Will *Roe v. Wade* now be read to demand judicial prohibition of legislative responses to the problems of the disposal of the remains of discarded individual human life?

The judicial and judicious answer is that the appropriate branch of government, a legislature, must so provide for the humane disposal of aborted human remains. S. Rep. No. 465, *supra* at 4, 5.

A "substantive due process" answer is of course by its nature arbitrary and not so predictable. Epstein, *Substantive Due Process By Any Other Name: The Abortion Cases*, 1973 Supreme Court Review 159; Viera, *Roe and Doe: Substantive Due Process and the Right of Abortion*, 25 Hastings L. J. 867 (1974).

The unforeseen impact and result of the Court's "substantive due process" abortion legislation and the eroding factual base upon which the regulations were so enacted indicate it is time we begin to journey back to a sane and rational jurisprudence that respects the constitutional separation of powers. S. Rep. No. J-97-16, *supra*; S. Rep. No. 465, *supra*.

"Substantive due process" -- an oxymoron -- should once again be laid to rest. Humane recognition of our own is clearly within the power of the legislature. It is a Constitution not a *Zeitgeist* this Court is charged to interpret, and it is that duty to which the Court is urged to return. Article III creates a judiciary, not a peerage.

III. Conclusion

The passage of time cannot cure "an improvident and extravagant exercise of the power of judicial review" made without "authority," *Roe* v. *Wade*, 410 U.S. at 221-222 (White, J., dissenting); and "judicial legislation," *Id.* at 174 (Rehnquist, J., dissenting), like all legislation, is subject to becoming outdated rapidly.

Nine years after *Plessy* v. *Ferguson*, 163 U.S. 537 (1896), the Constitution was still "color blind," (Harlan, J., dissenting); and nine years after *Roe* v. *Wade* the "exercise of raw judicial power," *Id.* at 221-222 (White J., dissenting) is still raw and eroding the authority upon which judicial power must ultimately rest.

To come before the Court and say the truth is to be a friend of the Court.

It is a lack of respect for the Court in argument to attempt to intellectualize the irrational and overreaching "substantive due process" categories which the unconstitutional *Roe* v. *Wade* blandly states.

A case regularly criticized in law reviews, *see* S. Rep. No. 465, *supra* at 34 and critical articles cited therein; J. Noonan, A Private Choice: Abortion in America in the Seventies, 20-32 (1979), and a topic of lampooning in law classes across the country cannot be salvaged by obsequious fawning, masking itself as scholarship. It should be and will be disavowed.

At the very least though, at this time we should expect a legal recognition of that most fitting and

proper right to respect and humanely care for the human life sacrificed.

Whether this Court will be allowed to seize upon this opportunity to begin to properly interpret the Constitution by limiting or disavowing the unconstitutional *Roe v. Wade* is not a matter within the powers of the Court or those before it. Not just because of the power and sway of vested error, by comparison to which vested wealth is naught, but more because the blood, guilt, and accumulated self-hatred of nine years is heard.

"Then I shall make Pharoah's heart stubborn and he will set out in pursuit of them. But I shall win glory for myself at the expense of Pharoah and all his army and the Egyptians will learn I am Yahweh." *Exodus* 14:4.

Respectfully submitted,

Charles E. Rice
Notre Dame Law School
Notre Dame, Indiana 46556
(219) 239-5667
Counsel of Record for Amicus Curiae

Thomas Patrick Monaghan
General Counsel
Catholic League for Religious and
Civil Rights
1100 West Wells Street
Milwaukee, Wisconsin 53223
Attorney for Amicus Curiae

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No. 81-746

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF AMICUS CURIAE OF THE COLLEGE OF AMERICAN PATHOLOGISTS IN SUPPORT OF RESPONDENT AKRON CENTER ON THE SIXTH QUESTION PRESENTED

JACK R. BIERIG
SIDLEY & AUSTIN
One First National Plaza
Suite 4800
Chicago, Illinois 60603
(312) 853-7000

Counsel of Record

TABLE OF CONTENTS

	PAGE
Table of Authorities	ii
INTEREST OF AMICUS CURIAE	1
STATEMENT OF THE CASE	3
SUMMARY OF ARGUMENT	4
ARGUMENT—A REQUIREMENT OF "HUMANE" DISPOSAL OF ABORTUS MATERIAL IS VOID FOR VAGUENESS	5
CONCLUSION	10
Appendix	A1

TABLE OF AUTHORITIES

CASES

	PAGE
Akron Center for Reproductive Health v. *City of Akron*, 479 F.Supp. 1172 (N.D. Ohio 1979), *aff'd.*, 651 F.2d 1198 (6th Cir. 1981)	3, 4
Colautti v. *Franklin*, 439 U.S. 379 (1979)	6, 7
Doe v. *Bolton*, 410 U.S. 179 (1973)	7
Grayned v. *City of Rockford*, 408 U.S. 104 (1972)	6
Planned Parenthood Assn. v. *Fitzpatrick*, 401 F.Supp. 554 (E.D. Pa. 1975), *aff'd. mem. sub. nom. Franklin* v. *Fitzpatrick*, 428 U.S. 901 (1976)	9
Roe v. *Wade*, 410 U.S. 113 (1973)	7
Village of Hoffman Estates v. *Flipside, Hoffman Estates, Inc.*, U.S. , 102 S.Ct. 1186 (1982)	7, 9

STATUTES AND ORDINANCES

Codified Ordinances of the City of Akron, § 1870.16	*Passim*
Codified Ordinances of the City of Akron, § 1870.18	7
Health and Safety Code of California, § 7054.3	8
Health and Safety Code of California, § 25957(a)	8
Mont. Code Ann. § 50-20-105(1)	2
Ohio Admin. Code § 3701-47-01(E)	5
Ohio Admin. Code § 3701-47-05(A)	9
Ohio Rev. Code Ann. § 2923.02(A)(2)	3
Ohio Rev. Code Ann. § 4731.22(B)(18)	6
35 P.S. § 6605(c) (Pennsylvania)	2

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INTEREST OF AMICUS CURIAE

This brief is submitted by the College of American Pathologists on the sixth question presented in the petition for certiorari—whether the Akron ordinance at issue in this case is constitutional insofar as it provides that:

> "Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a humane and sanitary manner."

The brief is being filed with the consent of all parties.[1]

The College of American Pathologists has a special interest in any statute, ordinance, or regulation governing the disposal of abortus tissue. The College is comprised of nearly 8,500 physicians board-certified in the specialty of pathology. As part of their medical practice, some of these physicians are called upon to perform autopsies on aborted fetuses and to analyze embryonic tissue. In these circumstances, the pathologist may be responsible for disposing of the abortus.

With respect to the specific question presented here, the College and its members have a direct stake in whether an ordinance requiring "humane" disposal of the abortus is constitutional. This standard leaves pathologists without meaningful guidance as to whether customary disposal methods comport with law. It exposes pathologists to the risk of prosecution simply because a local official or jury may not regard such methods as "humane."

To be sure, the disposal provision of the Akron ordinance before the Court is directed only to the physician who performs the abortion. If the "humane" standard is upheld in this case, however, that standard can be applied to pathologists. Indeed, existing statutes requiring "humane" disposal are broad enough to cover the pathologist.[2] Moreover, even under the Akron ordinance, a prosecution might be brought against a pathologist on an aiding or abetting

[1] Copies of the consents are printed in the Appendix.

[2] Thus, for example, Pennsylvania law provides that the Department of Health "shall make regulations to provide for the humane disposition of dead fetuses." 35 P.S. § 6605(c). Similarly, Montana law provides that the Department of Health and Environmental Sciences "shall make regulations to provide for the humane disposition of dead infants or fetuses." Mont. Code Ann. § 50-20-105(1).

theory.[3] For all these reasons, the College of American Pathologists offers this brief as amicus curiae.

STATEMENT OF THE CASE

This case involves a broad challenge to the constitutionality of § 1870 of the Codified Ordinances of the City of Akron, a 1978 ordinance which regulates abortions. The only aspect of the ordinance addressed by this brief is § 1870.16. That section requires disposal of the remains of an unborn child in "a humane and sanitary manner."

Respondent Akron Center for Reproductive Health challenged the constitutionality of, *inter alia*, the "humane" disposal requirement of § 1870.16. Both the district court and the Court of Appeals found that this requirement was unconstitutionally vague. *Akron Center for Reproductive Health* v. *City of Akron*, 479 F.Supp. 1172 (N.D. Ohio 1979), *aff'd.*, 651 F.2d 1198 (6th Cir. 1981). The district court concluded that:

> "The appropriate method for Akron's city council to have followed to insure that aborted fetuses are disposed of in a manner that they considered 'humane,' would have been to specifically state what methods of disposal were not or, alternatively, were acceptable. Accordingly, the Court finds Section 1870.16 void for vagueness." 479 F.Supp. at 1206.

The Court of Appeals ruled that the district court had "correctly found section 1870.16 invalid on grounds of vagueness." 651 F.2d at 1211. It noted that the "possibility that the language of section 1870.16 might be construed to mandate some sort of 'decent burial' of an embryo at the

[3] Ohio Rev. Code Ann. § 2923.02(A)(2) provides that "(n)o person, acting with the kind of culpability required for the commission of an offense shall . . . aid or abet another in committing the offense."

earliest stages of formation is too real to be overlooked." *Id.*

This Court granted certiorari to review a number of issues decided by the Court of Appeals. The sixth question presented to this Court was "(w)hether the term 'humane' as it relates to the disposal of fetuses in Section 1870.16 is void for vagueness, and if so, whether the term is severable from the balance of the section. . . ." It is to that question that this brief is addressed.

SUMMARY OF ARGUMENT

Section 1870.16 is void for vagueness insofar as it requires "humane" disposal of the abortus. It sets forth no objective standard by which physicians can determine whether the disposal methods that they use, *i.e.*, group burial or cremation, comport with law. Instead, § 1870.16 exposes physicians to prosecution and possible conviction because local officials and juries may believe that these methods are not "humane"—or simply because they wish to punish all who are in any way connected with an abortion.

The vagueness of the "humane" disposal standard is particularly intolerable for several reasons. The requirement threatens to inhibit the exercise of privacy rights protected by the Fourteenth Amendment by burdening a woman's decision to have a lawful abortion. In addition, it exposes the physician not just to civil penalties, but to the extreme sanction of criminal conviction. Moreover, it does so even if the physician had no intent to violate the law. For these reasons, the "humane" disposal requirement of § 1870.16 violates due process of law as guaranteed by the Fourteenth Amendment.

ARGUMENT

A REQUIREMENT OF "HUMANE" DISPOSAL OF ABORTUS MATERIAL IS VOID FOR VAGUENESS

Abortus material is frequently sent to a hospital laboratory for evaluation by the pathologist. Examination of the abortus by a pathologist can yield information useful both in counseling the parents and in advancing medical science. In the case of a spontaneous abortion, examination may indicate the cause of the abortion and thus may suggest the risks of, and precautions to be followed in, any subsequent pregnancies. In the case of an abortion induced out of fear of a genetic or other developmental defect, examination can determine whether or not the perceived defect actually existed. Thus it can be of significance in determining the reliability of pre-natal tests and in providing information on the risks inherent in subsequent pregnancies. Whenever the abortus material is abnormal, examination can help ascertain the etiology of the abnormality and thus contribute to an understanding of disease.

After examination by the pathologist has taken place, the abortus must be disposed of. Where it is still an embryo,[4] the abortus is treated like any other tissue removed from the human body through amputation, excision, or biopsy. Specifically, it is held in the laboratory for some period of time, then discarded, and subsequently either incinerated or buried with other refuse.

Where the abortus is a fetus, the parents may make arrangements for private burial. If they do, the fetus will be

[4] In most states, a conceptus is regarded as an embryo for approximately the first twenty to twenty-two weeks of gestation, depending on state law. Thereafter, the embryo has developed sufficiently to be regarded as a fetus. Under Ohio law, a conceptus is considered an embryo only for the first fourteen weeks. Ohio Admin. Code § 3701-47-01(E).

held in the hospital until picked up by the authorized agent. If the parents choose not to make arrangements, the hospital arranges for disposal. Generally, disposal is accomplished either by burial or cremation. A number of fetuses will be buried in a single casket or cremated at the same time.

Amicus College of American Pathologists believes that these procedures are humane. They allow the parents to make whatever arrangements they wish. At the same time, these procedures provide for efficient disposal of the abortus in a manner commensurate with the level of fetal development.

Section 1870.16, however, sets no objective standard by which a physician can readily determine whether these commonly used procedures comport with law. It "may trap the innocent by not providing fair warning." *Grayned* v. *City of Rockford*, 408 U.S. 104, 108 (1972). The "humane" disposal requirement exposes physicians to prosecution and other sanctions[5] because local officials and juries may not regard group burial or cremation of fetuses as humane—or simply because they wish to punish all who are in any way connected with an abortion. In other words, it impermissibly delegates basic policy matters to prosecutors, judges, and juries "for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application." *Id.* at 109. Thus, § 1870.16 offends the Constitution, for it is "a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Id.* at 108. See *Colautti* v. *Franklin*, 439 U.S. 379, 390 (1979).

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[5] Under Ohio law, the state medical board may revoke or suspend a physician's license for violating "any abortion rule adopted by the public health council. . . ." Ohio Rev. Code Ann. § 4731.22 (B) (18).

Most relevant in this connection is the recent observation by this Court that "(t)he degree of vagueness that the Constitution tolerates—as well as the relative importance of fair notice and fair enforcement—depend on the nature of the enactment." *Village of Hoffman Estates* v. *Flipside, Hoffman Estates, Inc.*, U.S. , 102 S.Ct. 1186, 1193 (1982). Here, the "nature of the enactment" underscores the unconstitutionality of § 1870.16.

As the Court pointed out in *Hoffman Estates*, "perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights." 102 S.Ct. at 1193. A requirement of "humane" disposal of the abortus "threatens to inhibit the exercise of" privacy rights protected by the Fourteenth Amendment. See *Roe* v. *Wade*, 410 U.S. 113 (1973); *Doe* v. *Bolton*, 410 U.S. 179 (1973). Specifically, the only method of disposal that would unquestionably satisfy the "humane" standard is an individual funeral for each abortus. The high costs of that approach would surely affect a woman's decision to have an abortion. Moreover, the vagueness of the "humane" disposal requirement might deter physicians from performing abortions. This development would, of course, burden the decision concerning an abortion.

Other features of § 1870.16 also point to the conclusion that the "humane" disposal requirement is unconstitutionally vague. A lesser degree of vagueness is tolerated where a law provides for criminal penalties. *Hoffman Estates, supra*, 102 S.Ct. at 1193. Noncompliance with § 1870.16 is a criminal offense punishable as "a misdemeanor of the third degree . . ." Codified Ordinances of the City of Akron, § 1870.18. The absence of a scienter requirement acerbates matters still further. *Hoffman Estates, supra*, 102 S.Ct. at 1193; *Colautti, supra*, 439 U.S. at 395. Section 1870.16 con-

tains no requirement of *mens rea* or intent to violate the law. The prescribed penalty attaches simply upon disposal of the abortus in a manner subsequently determined not to be "humane." In sum, § 1870.16 is void for vagueness insofar as it requires "humane" disposal of abortus material.

The City of Akron advances three arguments to support a contrary conclusion. First, it indicates that the intent of § 1870.16 is merely "to preclude the mindless dumping of aborted fetuses on garbage piles." Brief for Petitioner (Pet. Br.), at 48. This argument only points up the constitutionally unacceptable vagueness of the ordinance. If Akron wants to prohibit "dumping of aborted fetuses on garbage piles," it can—as both the district court and Court of Appeals suggested—easily write an ordinance to that effect. Alternatively, it can provide that abortus material must be disposed of either by burial or incineration. Indeed, the State of California has done precisely that.[6] A more tightly-drawn ordinance would accomplish Akron's objective while avoiding the vagueness problems inherent in the "humane" disposal standard.

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[6] Section 7054.3 of the Health and Safety Code of California, West's Ann. Health and Safety Code § 7054.3, provides that "(n)otwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration." Similarly, § 25957(a) of the Health and Safety Code, West's Ann. Health and Safety Code § 25957(a), provides as follows:

> "... at the conclusion of any scientific or laboratory research or any other kind of experimentation or study upon fetal remains, such fetal remains shall be promptly interred or disposed of by incineration.
>
> Storage of such fetal remains prior to the completion of the research, experimentation, or study shall be in a place not open to the public, and the method of storage shall prevent any deterioration of the fetal remains which would create a health hazard."

Second, the City suggests that the "humane" disposal requirement was upheld in *Planned Parenthood Assn.* v. *Fitzpatrick*, 401 F.Supp. 554, 573 (1975), *aff'd. mem. sub nom. Franklin* v. *Fitzpatrick*, 428 U.S. 901 (1976). Pet. Br. at 48. In fact, however, the statute at issue there provided only that the State Department of Health "shall make regulations to provide for the humane disposal of dead fetuses." As the district court pointed out in that case, the provision in question was "merely an enabling statute." 401 F.Supp. at 573. It imposed no obligation on private parties until the Department issued regulations. Accordingly, the court held that any challenge to the constitutionality of the "humane" disposal requirement should await the issuance of regulations. *Id.* Here, by contrast, the Akron ordinance directly affects regulated parties. It is operative even without the issuance of regulations. Thus the vagueness problems that it presents are not avoided, but rather exacerbated, by the absence of regulations.[7]

Finally, the City asserts that its ordinance is not void for vagueness because it "was largely taken from a state regulation which provides that 'the fetus shall be disposed of in a humane manner.' " Pet. Br. at 48. The City's conclusion does not follow from the point it makes. If anything, reliance on the Ohio regulation undercuts the City's position. For that regulation fails to define the meaning of the term "humane."[8] It leaves regulated parties without any guidelines whatsoever.

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[7] Significantly, Akron has not issued any regulations limiting the term "humane" and does not appear to have a mechanism for publishing any regulations. See *Hoffman Estates, supra*, 102 S.Ct. at 1193.

[8] The regulation states only that "(t)he fetus shall be disposed of in a humane manner." Ohio Admin. Code § 3701-47-05(A).

The City of Akron has offered nothing to alter the conclusion that a requirement of "humane" disposal of abortus material is void for vagueness. Perhaps recognizing this, the City concludes that the "humane" disposal requirement might be severed from the portion of the ordinance providing for sanitary disposition of abortus material. Amicus College supports this approach. The requirement of sanitary disposal is both understandable and proper.

CONCLUSION

For the foregoing reasons, amicus College of American Pathologists suggests that the judgment of the Court of Appeals be affirmed insofar as it holds that the requirement of "humane" disposal of abortus material in § 1870.16 is void for vagueness.

Respectfully submitted,

JACK R. BIERIG
SIDLEY & AUSTIN
One First National Plaza
Suite 4800
Chicago, Illinois 60603
(312) 853-7000

July 29, 1982

Jack R. Bierig, Esq.
Sidley & Austin
1 First National Plaza
Suite 4800
Chicago, IL 60603

Dear Mr. Bierig:

On behalf of Akron Center for Reproductive Health Inc., et al., I consent to the filing of an *amicus curiae* brief on behalf of the College of American Pathologists in *Akron Center for Reproductive Health* v. *City of Akron*, U.S. Nos. 81-746; 81-1172.

Sincerely,

/s/ Stephan A. Landsman
Counsel of Record
On behalf of Akron
Center for Reproductive
Health, Inc.

July 30, 1982

Marc Baum
Sidley & Austin
1 First National Plaza
Chicago, Illinois 60603

Re: Akron Center for Reproductive Health
v. City of Akron
Nos. 81-746 & 81-1172

Dear Mr. Baum:

As attorney for Patricia K. Black and Francois Seguin, M.D., respondents in the above-captioned case now pending in the United States Supreme Court, I hereby consent to the participation in this case by the College of American Pathologists as amicus curiae.

Very truly yours,

/s/ Alan G. Segedy
of Segedy & Umbaugh
On behalf of Patricia K.
Black and Francois
Seguin, M.D.

August 6, 1982

Jack R. Bierig
c/o Sidley & Austin
One First National Plaza
Chicago, Illinois 60603

Dear Mr. Bierig:

In response to your organization's request to file an amicus brief in Case No. 81-746 and/or 81-1172, Supreme Court of the United States, and in accordance with Supreme Court Rule 36(2), consent is hereby given for your organization to file a brief of amicus curiae.

Opposing counsel and the undersigned have agreed that consent could be given to any organization desiring to file an amicus curiae brief, on either side of the issues. If consent of counsel for the opposing party is denied, please notify the undersigned immediately.

Finally, please be sure to serve a copy of your brief upon counsel for all parties.

Very truly yours,

/s/ Robert D. Pritt
Director of Law
City of Akron
On behalf of City of
Akron

MOTION FILED AUG 4 1982

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND ANNEXED BRIEF OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

NADINE TAUB
15 Washington St.
Newark, New Jersey
(201) 648-5634

SYLVIA A. LAW
40 Washington Sq. So.
New York, N.Y. 10012
(212) 598-7642

ELLEN J. WINNER
Rabinowitz, Boudin, Standard,
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10012

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Respondents.

INDEX

Table of Authorities ii

Motion for Leave to File Brief Amici Curiae viii

Brief Amici Curiae 1

Interest of the Amici 2

Summary of Argument 2

Argument:

I. Historically Differences in Reproductive Capacity of Men and Women Have Provided A Primary Justification for Laws Creating a Separate, Inferior Status for Women 4

II. Laws Restricting Access to Reproductive Health Services Impose Enormous and Disproportionate Burdens on Women 17

III. The Restrictive Abortion Regulations Challenged Here Single Out Abortion From All Other Medical Services, Impose Requirements That Perpetuate Destructive, Inaccurate Stereotypes of Women and Coerce Women to Accept Their Maternal Destiny 25

CONCLUSION. 48

TABLE OF AUTHORITIES

CASES:

Aiken v. Cleary, 396 S.W.2d 668 (Mo. Sup. Ct. 1965)	29
Akron Ctr. for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 651 F.2d 1198 (6th Cir. 1981)	36, 47
Bellotti v. Baird, 428 U.S. 132 (1976)	34
Bradwell v. Illinois, 83 U.S. (16 Wall) 130 (1873)	7, 9
Breedlove v. Suttles, 302 U.S. 277 (1937)	13
Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert denied, 409 U.S. 1064 (1972)	27
Carey v. Population Services Intl., 431 U.S. 678 (1977)	19
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Cleveland Board of Education v. LaFleur, 414 U.S. 632 (1974)	12
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Frontiero v. Richardson, 411 U.S. 677 (1973)	6, 40, 43
Gary-Northwest Indiana Women's Services v. Bowen, 451 U.S. 934 (1981)	47
Harper v. Virginia State Brd. of Elections, 383 U.S. 663 (1976)	13
Hoyt v. Florida, 368 U.S. 57 (1961)	14
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Mississippi University for Women v. Hogan, 50 U.S.L.W. 5068 (1982)	3, 6, 16, 38, 45
Muller v. Oregon, 208 U.S. 412 (1908)	9, 10
Nashville Gas Co. Tenn. v. Satty, 434 U.S. 136 (1977)	12
Orr v. Orr, 440 U.S. 268 (1979)	5, 38

Planned Parenthood Ass'n of Kansas City v. Ashcroft, 483 F. Supp. 679, 664 F.2d 687 (8th Cir. 1981)	31, 36, 46
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Roe v. Wade 410 U.S. 113 (1973)	XVI, 16, 21, 25, 32
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Union Pacific Railway Co. 141 U.S. 250 (1891)	20

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Ohio Rev. Code Ann. §2317.54 (1976)	29
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U.S. Const. amend XIII 20

U.S. Const. amend XXIV 13

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Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
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Plaintiffs-Petitioners
v.
City of Akron, et al.,
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Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia and on Certiorari to the United States Court of Appeals for the Sixth Circuit and the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

The undersigned, as counsel for the Committee for Abortion Rights and Against Sterilization Abuse (CARASA), The National Bar Association (Women Lawyers Division), The National Emergency Civil Liberties Committee (ECLC), The National Lawyers Guild, The National Women's Health Network, and The Reproductive Rights National Network, respectfully move this Court for leave to file the accompanying brief amici curiae.

Amici organizations have all been actively involved in representing the interests of women adversely affected by legal restrictions on access to safe abortion services. Amici organizations support rights of reproductive freedom, including the rights to choose parenthood, to obtain abortions

and to be free from involuntary and coerced sterilization. Amici are particularly concerned that state action making abortion services expensive and inaccessible have a disporportionately harsh burden on poor, working and minority women.

THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE (CARASA) was formed in 1977 in response to the reaction against gains that women achieved in relation to sex based equality and reproductive freedom. It was founded by concerned women, who feared that poor women's limited access to abortion and the easy availability of sterilization would increase the incidence of sterilization abuse.

CARASA has several hundred active members working in the community to educate and organize people, and in the legislature to assure access to abortion, freedom from involuntary sterilization and a decent quality of life in which people can raise their children.

THE NATIONAL BAR ASSOCIATION, WOMEN LAWYERS DIVISION, founded in 1925, is a professional membership organization which represents more than 13,000 Black attorneys, judges and law students. Its purposes include achieving equal opportunities for minorities in the legal profession and protecting the civil and political rights of all citizens. To effectuate its goal of racial and sexual equality,

the National Bar Association, through its Women's Division, has been actively involved in issues concerning child abuse and reproductive freedom.

THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE ("ECLC") is a not-for-profit organization dedicated to the defense of the Bill of Rights and its extension to all our people -- particularly the poor and the powerless. Founded in 1951, the organization has worked to achieve these goals through litigation and public education. Among the cases it has sponsored in this Court are Kent v. Dulles, 357 U.S. 116, Kleindienst v. Mandel, 408 U.S. 753, and Law Students Civil Rights Research Council, Inc. v. Wadmond,

401 U.S. 154. Through similar means, it has sought to protect the right of reproductive freedom and the right to equal protection of the law at issue in this case.

THE NATIONAL LAWYERS GUILD ("NLG") is an organization of 7,000 lawyers, law students and legal workers dedicated to the goal of full equality for all people. Since its inception in 1937, the NLG has worked consistently for the advancement of the rights of poor and working people, racial minorities and women.

In the past decade, its work to support the women's movement has become an organizational priority. The National Lawyers Guild, a founding member of the Reproductive Rights

National Network, is actively involved in protection of reproductive rights for poor, minority and working women. Individual NLG members, in cases brought throughout the nation, represent litigants seeking to prevent cutbacks in abortion funding or attempting to end sterilization abuse.

THE NATIONAL WOMEN'S HEALTH NETWORK is a national consumer organization which focuses on women's health. It has 10,000 individual members and, in addition, 300 organizational members including health centers, consumer groups and women's health organizations. It is the only national consumer organization focusing on a broad range of women's health issues.

THE REPRODUCTIVE RIGHTS NATIONAL NETWORK is a national organization working to defend abortion rights, end sterilization abuse, reduce infant mortality, assure adequate childcare services, and promote lesbian rights. More than 80 organizations participate in the NETWORK, doing activist work on reproductive health issues from a feminist prospective.

The annexed brief argues that Commonwealth of Virginia, the City of Akron, and the State of Missouri violate the constitutional rights of women by placing onerous and wholly unjustified restrictions on access to abortion. Because these restrictive laws are premised upon and perpetuate inaccurate stereotypes about the

incompetence of women, the constitutional guarantee of sex based equality, as well as the constitutional right to privacy recognized in Roe v. Wade, compell invalidation of the challenged provisions.

We have sought the consent of the parties to file this brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

Respectfully submitted,

Sylvia A. Law

Sylvia A. Law
40 Washington Sq. So.
New York, N.Y. 10012

Nadine Taub
15 Washington St.
Newark, N.J.

Ellen J. Winner
Rabinowitz, Boudin, Standard,
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10012

Nos. 81-185, 81-746 and 81-1172,
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On Appeal from the Supreme Court of Virginia and on Certiorari to the United States Court of Appeals for the Sixth Circuit and the United States Court of Appeals for the Eighth Circuit

---

BRIEF AMICI CURIAE OF THE COMMITTEE FOR ABORTION RIGHTS AND AGAINST STERILIZATION ABUSE, THE NATIONAL BAR ASSOCIATION (WOMEN LAWYERS DIVISION), THE NATIONAL EMERGENCY CIVIL LIBERTIES COMMITTEE, THE NATIONAL LAWYERS GUILD, THE NATIONAL WOMEN'S HEALTH NETWORK, AND THE REPRODUCTIVE RIGHTS NATIONAL NETWORK

This brief is submitted by the undersigned amici curiae conditionally upon the granting of the motion for leave to file to which it is attached.

INTEREST OF AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

Until quite recently, the law sharply restricted the opportunities of women in wage work and public life. A central justification for such laws was to protect and maintain women in their biologically ordained role as mothers. Since 1971 this Court has repeatedly affirmed that gender based laws "must carry the burden of showing an 'exceedingly persuasive justifica-

tion'. . ." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

State action restricting access to abortion imposes onerous costs upon women. In the guise of protecting women, such laws compel an enormous sacrifice of women's physical integrity and personal autonomy.

The laws challenged in these cases require that physicians abandon standard medical practice and considered professional judgment; criminal penalties enforce compliance. In the many areas where hospitals are inaccessible to physicians providing abortions, the effect of the "protective" hospitalization requirement is to force the woman to endure an unwanted pregnancy. Similarly, the mandatory "informed"

consent and waiting period requirements exact high costs from women and physicians, solely to perpetuate the inaccurate stereotype of the woman as incapable of moral and practical decisionmaking, and to force her to accept her maternal destiny.

ARGUMENT

I. Historically Differences in Reproductive Capacity of Men and Women Have Provided A Primary Justification for Laws Creating a Separate, Inferior Status for Women.

Since 1971 this Court has repeatedly recognized that "legislative classifications which distribute benefits and burdens on the basis of gender carry the inherent risk of reinforcing the stereotypes about the 'proper place' of women and their need

for special protection." Orr v. Orr, 440 U.S. 268, 283 (1979). Laws premised on stereotypes about men and women are destructive, and constitutionally infirm, not only because they hurt individual men and women who do not fit the stereotype, but also because they are self-fullfilling. As the Court stated, in striking down the Utah law requiring that parents support their male children until age 21 and their female children only until age 18:

> No longer is the female destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas. . .If the female is not to be supported so long as the male, she hardly can be expected to attend school as long as he does, and bringing her education to an end earlier coincides with the role-typing

> society has long imposed. Stanton v. Stanton, 421 U.S. 7, 14-15 (1975).

Only last term, this Court eloquently reaffirmed that "the party seeking to uphold a statute that classifies individuals on the basis of their gender must carry the burden of showing an 'exceedingly persuasive justification' for the classification." Miss. Univ. for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982).

The Court and the country have not always been sensitive to the oppression of sex based discrimination. "There can be no doubt that our Nation has had a long and unfortunate history of sex discrimination." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). There is also no doubt

that this unfortunate history of sex discrimination was primarily justified by the differences in reproductive capacity of men and women. The biological fact that women are capable of bearing children has been used to legitimate legislation creating a separate system of rights and responsibilities for women, and judicial approval of laws to "protect" and maintain women in their biologically ordained role as mothers.

This Court's approval of separate spheres for men and women based on women's reproductive capacity was first set forth in Bradwell v. Illinois, 83 U.S. (16 Wall) 130 (1873). Myra Bradwell had met all the qualifications to become a member of

the Illinois bar except for one - she was not a male. The Court faced the question whether a state could deny her the occupation of her choice solely because she was female and answered that it could. Justice Bradley's concurrance is the classic statement of the 19th century view of women's place in this society:

> ...the civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman. Man is, or should be, woman's protector and defender. The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. The constitution of the family organization, which is founded in the divine ordinance as well as in the nature of things, indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood ...

> The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother. This is the law of the creator. And the rules of civil society must be adopted to the general constitution of things ... Bradwell v. Illinois 83 U.S. (16 Wall) at 141.

This "noble and benign" mission of motherhood denied Myra Bradwell the right to practice law; Justice Bradley perceived it was "the law of the creator," not the state, which constructed this dual system of rights.

Bradwell was only the beginning of this Court's endorsement of discrimination against working women in the guise of protection. In Muller v. Oregon, 208 U.S. 412 (1908), this Court again viewed women's anatomy as destiny.

> That women's physical structure and the performance of maternal functions place her at a disadvantage in the struggle for subsistence is obvious. This is especially true when the burdens of motherhood are upon her. Even when they are not, by abundant testimony of the medical fraternity continuance for a long time on her feet at work, repeating this from day to day, tends to injurious effect upon the body, and as healthy mothers are essential to vigorous offspring, the physical well-being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race. Muller, 208 U.S. at 421.

The need for a woman to "proper[ly] discharge her maternal function" justified the maximum hours law in Muller, 208 U.S. at 422, and other laws "protecting" women by limiting

their employment opportunities.[1] These laws helped create the sex segregated job market, with the more lucrative positions reserved for men.[2] By defining a job as requir-

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[1] See Women's Bureau, U.S. Dep't. of Labor, Summary of State Labor Laws for Women (1969), reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 729 (1970); Oldham, "Sex Discrimination and State Labor Laws," 44 Den. L.J. 344 (1967).

[2] See generally Blumrosen, "Wage Discrimination, Job Segregation and Women Workers," 6 Women's Rts. L. Rep. 19 (1979-80); Ross, Sex Segregation and "Protective" Labor Legislation, reprinted in Hearings on S.J. Res. 61 Before the Subcomm. on Const. Amendments of the Senate Comm. on the Judiciary, 91st Cong., 2nd Sess. 392 (1970). Furthermore, sex segregation in employment has not decreased and some indicators show it is actually increasing. See U.S. Comm'n on Civil Rights, Social Indicators of Equality for Minorities and Women (1978); U.S. Dept. of Labor, 1975 Handbook on Women Workers (1975).

ing overtime, night work, or heavy lifting, employers could completely disqualify women. Maximum hour laws denied women higher paid overtime work. Finally forced maternity leaves denied women work and seniority.[3/] These "protective" laws gave women the option of staying at home or taking employment in lower paid, less desirable jobs.

Employment was only one of the areas in which courts used biological differences to sanction laws denying women the rights and responsibilities

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3/ See e.g. the policies struck down in Nashville Gas Co. Tenn. v. Satty, 434 U.S. 136 (1977); Cleveland Board of Education v. LaFleur, 414 U.S. 632 (1974).

of male citizens. Women and the blind were given special "protection" by a Georgia statute requiring payment of a poll tax.[4/] "In view of the burdens necessarily borne by them for the preservation of the race, the State reasonably may exempt them [women] from poll taxes." Breedlove v. Suttles, 302 U.S. 277, 282 (1937). Unlike the blind, however, women were only exempt if they did not register to vote. The statute alleviated the tax burden by discouraging women from participating in the political process.

4/ The poll tax is now illegal by judicial decision, Harper v. Virginia State Brd. of Elections, 383 U.S. 663 (1976) and constitutional amendment, U.S. Const. amend XXIV.

Biology justified the exemption of women from jury duty. Finding that "woman is still regarded as the center of home and family life", this Court upheld a Florida statute automatically excluding women from serving on juries unless they registered with the court clerk. Hoyt v. Florida, 368 U.S. 57, 62 (1961). As recently as 1970 lower Federal courts upheld such exemptions. Following Hoyt, a Federal district court explained: "Granted that some women pursue business careers, the great majority constitute the heart of the home, where they are busily engaged in the 24 hour day task of producing and rearing children, providing a home for the entire family, and performing the

daily household work ..." Leighton v. Goodman, 311 F. Supp 1181, 1183 (S.D.N.Y. 1970).

Woman's role as a potential childbearer and childrearer justified a separate set of rights and responsibilities. Women were seen primarily responsible in the private sphere of home and family, while men's responsibilities were in the public sphere. Biological differences have been used to perpetuate an invidious system of discrimination against women. Under the banner of "protection" the law has justified a dual system of rights which prevented women from equal access to and participation in the public sphere in the glorification of motherhood.

Today, however, this Court rejects laws that create separate spheres for men and women by firmly and repeatedly affirming the Constitutional right to sex based equality under the law. See, most recently, Mississippi University for Women v. Hogan, supra. Since 1973 this Court has also affirmed that the Constitutional right to privacy prevents the state from denying women, and their physicians, access to the safe and legal abortion services that are essential to women's capacity to live as free, equal and autonomous citizens. See e.g., Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

II. Laws Restricting Access to Reproductive Health Services Impose Enormous and Disproportionate Burdens on Women.

Only women bear the physical burdens of pregnancy. These burdens range from minor discomfort to permanent damage to health to loss of life.[5/] When the state acts to restrict access to reproductive health services pregnant women are compelled to endure this physical invasion and the physical, psychological, and socio-economic consequences of it.

The value which the common law and constitution attach to the indivi-

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5/ G. Bourne and D. Danforth, Pregnancy (rev. ed. 1975). For an excellent summary see Regan, "Rewriting Roe v. Wade," 77 Mich L. Rev. 1569, 1579-83 (1979).

dual's right to control his or her own body is so high that people are not generally required to reach out to aid another, even when it is possible to save another person from grave injury.[6/]

6/ W. Prosser, The Law of Torts §56 (4th ed. 1971) 340-341.

> Consider a simple burning building, with a child trapped inside. Would a court impose criminal liability on anyone, even the child's parent, who did not attempt to save the child at the risk of second-degree burns over one or two percent of his or her body? . . . (A)n innocent life can be saved by a physical invasion comparable to or less than pregnancy and delivery. . . (E)ven if the potential rescuer is specified to be the child's parent, liability is unlikely. In all other cases, the suggested imposition is unthinkable in the context of our legal system.

Regan, "Rewriting Roe v. Wade," supra n.5 at 1558.

Laws restricting access to abortion impose upon one class of people, women, uniquely onerous obligations to endure physical intrusion to aid another.[7/] By restricting abortion and forcing

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7/ It is not possible to say that a pregnant women voluntarily assumes a duty to aid the fetus. No method of contraception is entirely effective. The one year failure rates for various methods of contraception range from 2% for pills to 10% for diaphrams and condoms to 40% for douche. R. Hatcher, et. al. Contraceptive Technology, 1982-1983 (11th Rev. Ed. 1982).

An assertion that women, by engaging in sex, voluntarily assume a duty to aid the fetus depends on the archaic, reprehensible, and constitutionally indefensible notion that women, but not men, may be punished for their sexual activity, and punished by being forced to bear a child. Eisenstadt v. Baird, 405 U.S. 438 (1972); Carey v. Population Services Intl., 431 U.S. 678 (1977).

a woman to carry a fetus to term, the state demands that women tolerate the most intrusive form of physical invasion of their bodies. The right to freedom from this type of physical intrusion has long been a part of our legal heritage:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control, of his own person ... Union Pacific Railway Co. 141 U.S. 250, 251 (1891).

Individual interests in freedom from state mandated intrusions on physical integrity are explicitly protected by the 13th Amendment's prohibition against involuntary servitude, the 8th Amendment's ban on cruel and unusual punishment, as well as the constitu-

tionally protected right to privacy.[8/]

The sexually differential impact of reproductive capacity is not limited to pregnancy itself. When reproductive health services are restricted, all heterosexually active women know that their life may be interrupted at any time by the short and long range risks

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8/ The constitutional right to privacy affirmed in Roe v. Wade has deep and strong historic roots. 410 U.S 113, 152 (1973). It prohibits laws restricting access to abortion, unless they are narrowly designed to serve compelling state purposes. This constitutional requirement is appropriately more rigorous than the heightened scrutiny demanded of ordinary sex based classifications; the enormity of the burdens that unwanted pregnancy imposes upon women and the centrality of control of reproductive capacity to women's equality as citizens, workers and human beings require no less.

and burdens of pregnancy.[9/] This in turn profoundly affects the ability of

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[9/] In Michael M. v. Sonoma County, 450 U.S. 464, 471 (1981) this Court recognized that pregnant women and girls confront:

> problems more numerous and more severe than any faced by her male partner. She alone endures the medical risks of pregnancy or abortion. She suffers disproportionately the social, educational, and emotional consequences of pregnancy.

In that case the Court found that the sexually disproportionate burdens which unwanted pregnancy imposes on women are so severe that the rigorous equal protection standard had been met, even though the fit between the sex based classification defining the crime of statutory rape and the objective of avoiding unwanted pregnancy was extremely tenuous. Here by contrast there is a direct, demonstrable relationship between state created barriers to abortion and severe, predictable injury to women.

women to plan their lives. By exacerbating this uncertainty, restrictions on reproductive health services pervasively undermine the ability of women to achieve and contribute in wage work and public life.

Technology sometimes allows human beings to transcend the limits of biology. We fly. We visit anartica and space. Advances in human understanding, science and medicine allow people greater control of reproductive capacity. When the state denies women access to reproductive health services, it is not nature, but the state, that prevents them from approaching the capacity for personal autonomy that

has traditionally been the perogative of men.[10/]

10/ Kenneth Karst, "Forward: Equal Citizenship Under the Fourteenth Amendment," 91 Harv. L. Rev. 1, 57, n.320 (1978) notes, "Only a lawyer (a male lawyer) could regard . . . laws (regulating pregnancy, abortion and contraception) as sex neutral."

Laurence Tribe, American Constitutional Law, (1978) p. 924, observes:

> If a man is the involuntary source of a child-if he is forbidden, for example, to practice contraception-the violation of his personality is profound; the decision that one wants to engage in sexual intercourse but does not want to parent another human being may reflect the deepest of personal convictions. But if a woman is forced to bear a child-not simply to provide an ovum but to carry the child to term-the invasion is incalculably greater. Quite apart from the physical experience of pregnancy itself, an experience which of course has no analogue for the male, there is the

(Footnote continues on following page)

III. The Restrictive Abortion Regulations Challenged Here, Single Out Abortion From All Other Medical Services, Impose Requirements That Perpetuate Destructive, Inaccurate Stereotypes of Women, And Coerce Women to Accept Their Maternal Destiny.

The constitutionally protected right to privacy prevents the state from restricting access to abortion, prior to viability, unless the state demonstrates that restrictions are narrowly designed to serve compelling interests in the promotion of maternal health. Roe v. Wade, 410 U.S. at 162-63. The restrictive regulations challenged here are not justi-

(Footnote continued from preceding page)

> attachment the experience creates, partly physiological and partly psychological, between mother and child. Thus it is difficult to imagine a clearer case of bodily intrusion, even if the original conception was in some sense voluntary.

fiable in relation to maternal health. Their purpose and effect is to demand the sacrifice of the health and well being of the woman.

All of the laws challenged in these three cases impose requirements for abortion that are very different from the legal restraint normally applicable to other medical procedures. For example the Akron and Missouri laws require that prescribed information be conveyed, that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the required information, and that the information be communicated by the physician. These requirements, like all the restrictions challenged in these cases, are enforced by imposing

criminal sanctions against the physician. These special requirements for abortion are all premised upon and perpetuate an inaccurate stereotype of women as incompetent, dependent upon male authority and incapable of moral decision making.

We support general requirements that written consent be obtained prior to any medical procedure, including abortion. Planned Parenthood v. Danforth, 428 U.S. 52, 65-67 (1976). Tort law requires consent prior to medical treatment, and, in most jurisdictions demands that the physician provide that information which a reasonably prudent person would want in deciding whether to undergo the proposed treatment. See e.g. Canterbury

v. Spence, 464 F.2d 772 (D.C. Cir.), cert denied, 409 U.S. 1064 (1972). At the heart of the informed consent requirement is the recognition, eloquently expressed by Benjamin Cardozo in 1914, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E.2d 92, 93 (1914). In 1976 Ohio codified the common law informed consent requirement, providing immunity from civil liability to doctors who use a consent form setting:

> forth in general terms the nature and purpose of the procedure, together with known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars

> associated with such procedures, with the probability of each such risk if reasonably determinable.

The general Ohio consent law also requires acknowledgment "that all questions asked about the procedure have been answered in a satisfactory manner." Ohio Rev. Code Ann. §2317.54 (1976). Consent to treatment is presumed to be legally valid if it meets these general requirements.[11/]

11/ Missouri common law requires that ". . . the patient is entitled to such information as he needs to make an intelligent decision and to give an informed intelligent consent." Roberson v. Menorah Medical Center, 588 S.W.2d 134, 137 (Mo. Sup. Ct. 1979). Doctors must provide such information as other physicians convey in comparable situations. Aiken v. Cleary, 396 S.W.2d 668, 674 (Mo. Sup. Ct. 1965).

The special abortion consent laws are constitutionally objectionable in that the explicit information required to be conveyed assume and perpetuate an inaccurate stereotype of women as incapable of moral decision-making. The Akron ordinance demands that she be told "that the unborn child is a human life from the moment of conception," and Missouri requires that she be informed of the "anatomical and physiological characteristics of the unborn child." A woman who experiences an unwanted pregnancy must make a decision. A woman who believes she is pregnant does not seek abortion services from a clinic or private physician, until and unless she makes a moral and personal choice to

terminate the pregnancy. The decision normally proceeds action to effectuate it.[12/]

12/ The trial court in Missouri found as a matter of fact on the basis of expert testimony "that, as a general proposition, women seeking abortions have completely thought out the abortion decision prior to approaching a clinic or personal doctor." Planned Parenthood Ass'n of Kansas City v. Ashrcoft, 483 F. Supp. 679, 696 (W.D. Mo. 1980)

Most abortions are provided in a relatively small number of large facilities. In 1980, 76% of abortions were performed in clinics serving 1000 or more abortion patient during the year. S. Henshaw, et. al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 10 (1982). The most common reason women offer for the decision to have an abortion is that they "would not be able to give a child a fair chance at this time." This was cited by over 80% of women seeking abortions. L. Shusterman, "Predicting the Psychological Consequences of Abortion," 13A Soc. Sci. & Med. 683, 686 (1979).

This Court recognized in Roe v. Wade that "those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus," as to when human life begins, and that there is a "wide divergence of thinking on this most sensitive and difficult question." 410 U.S. 160-61. These laws reflect a false and demeaning presumption that the state and the physician are more competent to make this moral decision than is the woman.

The laws also reflect an inaccurate stereotype of women as incompetent to make practical choices. Akron commands the physician to inform the woman that "numerous public and private agencies and services are available to assist

her during the pregnancy and after the birth of her child," and Missouri law requires that she be given a list of such services. The physician and the state are not in a better position than the woman to evaluate the "public and private agencies and services" available to help her if she should bear a child.[13/] As Justice Stevens

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13/ The reality is that for many women the birth of a child condemns them to continued, desperate poverty. The American Promise: Equal Justice and Economic Opportunity, the Final Report of the National Advisory Council on Economic Opportunity (1981) documents that during the 1970's "more of the poor were women, and more women, especially those heading families with minor children, became poor." Inadequate public and private support services impose an "unusual amount of stress" on poor women that "exacts a toll on their physical and emotional health." Id. at p. 7.

observed, in discussing parental involvement in a minor's decision making, "the most significant consequences of the decision are not medical in character. . ." Bellotti v. Baird, 428 U.S. 132, 103 (1976). The abortion decision is profoundly moral and personal, as well as medical. The special consent laws for abortion both reflect the stereotype of woman as incapable of making significant life choices and attempt to force her to fulfill the "noble and benign" mission of motherhood.

The informed consent provisions do not treat the woman as a human being with a "right to determine what shall be done with her own body," but rather as confused and disoriented.

The ordinance requires that the doctor inform her that abortion "may leave unaffected" any psychological problems she may have. A law requiring the communication of information as self-evident and frivolous as this does not treat the woman as a competent person.

The requirements that the women wait, 24 hours in Akron and 48 hours in Missouri, after receiving the prescribed information ratify archaic stereotypes about the changability and indecisiveness of women. The trial courts below found that the waiting period "requires the patient to make two trips to the clinic instead of one," with attendant increases in travel, child care, and work loss

expenses.[14/] As the Circuit Court recognized in the Akron case, the "unstated" purpose of the mandatory waiting period is "to require a 'cooling off period' during which second thoughts might come into play." 651 F.2d at 1208.

14/ Akron Ctr. for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1204-05; the waiting period "has, in fact, a detrimental effect on the health interests of women seeking abortions and . . . is unduly burdensome. . . " Planned Parenthood Ass'n of Kansas City v. Ashcroft, 483 F. Supp 679, 696. All the Circuit Courts that have considered fixed mandatory waiting periods after counseling and before abortion have found no medical justification for the inflexible waiting requirement. See Akron Center, 651 F.2d at 1208; Ashcroft, 655 F.2d 848, 866; Charles v. Carey, 627 F.2d 722, 785-86 (7th Cir. 1980); Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006, 1014-16 (1st Cir. 1981).

As we have noted, the abortion decision normally proceeds action seeking an abortion. What then is the purpose of singling out this service, and demanding that women "think twice "? The waiting period embodies and perpetuates the classic stereotype of the changeable woman.[15/] The waiting period exacts substantial costs in terms of time, convenience, travel, and money; it inevitably in-

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15/ Virgil tells us "A woman is always a fickle, unstable thing." Francis I of France explains, "Woman often changes; foolish the man who trusts her." The poet, Aaron Hill says, "First, then, a woman will or won't, depend on it." Alexander Pope opinioned, "Women's at best a contradiction still." J. Bartlett, Familiar Quotations, pp. 118, 400, 407 (14th ed. 1968.)

creases medical risk. A law causing concrete harm to women and supported by nothing but sex based stereotypes cannot stand. Stanton v. Stanton, supra; Orr v. Orr, supra; Mississippi University for Women v. Hogan, supra.

The requirement of the Akron and Missouri laws that the physician personally communicate this prescribed information is also demeaning to the woman. As we have seen, some of the information required is trivial or untrue; much of it does not relate to medicine or physical or emotional health, but rather to misplaced moral and social concerns. A law denying the physician's normal authority to delegate educational and communication tasks to others increases the

cost of the abortion. It has no effect other than to restrict access to abortion and to deny the decision making competence of the woman patient.

Finally, the restrictive laws challenged in these three cases impose criminal penalties upon physicians who fail to comply with their mandate. Ordinary tort principles of informed consent treat the doctor/patient relationship as a private one; the doctor's superior knowledge, authority and skill give rise to the duty to provide information, but the law leaves enforcement of this duty to private agreement and civil action. Criminal sanctions provide special "protection" for women seeking abortions. As has so often been true of laws providing "special

protection" for women, these policies reflect "an attitude of 'romantic paternalism' which, in practical effect, put women not on a pedestal but in cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). Doctors who do not wish to confront the Hobson's choice of either personally communicating information they believe to be false or risking punishment as criminals can simply abstain from performing abortions. The shortage, in many areas total unavailability, of physicians willing and able to perform

abortions is exacerbated.[16/] In the name of providing women "special protection" from uninformed decision-making, these laws create often insurmountable obstacles to effectuation of the women's choice. Laws mandating criminal punishment for doctors who fail to communicate information that many might reasonably believe to be false impermissibly "confine the attending physician in an undesired and uncom-

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16/ In 1980, 78% of all U.S. counties had no identified provider of abortion services. S. Henshaw, "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 5 (1982). Only about 10% of obstetrician-gynecologists in private practice perform abortions in their offices. Id. at 12. Only 17% of public hospitals and 34% of private, general non-Catholic hospitals reported any abortions performed in 1980. Id. at 11.

fortable straightjacket in the practice of his profession." Planned Parenthood v. Danforth, 428 U.S. 52, 67, n. 8 (1976).

Each of these three cases also challenges the requirement that abortions performed after the 12th week of pregnancy be done in the hospital. In every other medical situation, competent adults, in consultation with their physicians are free from state constraint in choosing whether medical treatment requires hospitalization.[17/] The physician and patient choice whether or not to use hospital facilities is influenced by medical

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17/ See generally Curran and Shapiro, Law, Medicine and Forensic Science, Ch. 5 and 6 (1982).

factors, personal convenience, the availability of hospital facilities, and cost. In no other situation does the state demand that medical treatment be restricted to the hospital. Forcing women seeking abortions to use hospital facilities again reflects and reinforces the stereotype of women as incompetent, and in need of uniquely special state "protection."

The second trimester hospitalization requirement plainly has the practical effect of putting women, "not on a pedestal, but in a cage." Frontiero v. Richardson, 411 U.S. 677, 684 (1973). The evidence presented in each of these cases, confirms general data, showing that in most areas of the country there are no

hospitals in which second trimester abortions may be performed.[18/] So, in the name of "protecting" women from the dangers of out-patient abortions in the second trimester, these laws force women to travel to areas where hospitals are available or where doctors are legally free to exercise their own medical judgment that hospitalization is unnecessary. The "protection" of women imposes upon them enormous financial and emotional

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18/ Supra n. 16. Among the seriously limited number of hospitals providing any abortion services, 30% allow abortions only to women at 10 or fewer weeks gestation. Only 21% of hospitals allowing abortions will do so after 14 weeks gestation. S. Henshaw, et. al. "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives 5, 14-15 (1982).

costs, and increases risks to life and health as a result of the inevitable delay. Many women are unable to pay the price that the state exacts for their "protection," and will hence be forced to continue their pregnancy.

Because of our pervasive history of harming women through laws designed to provide them special protection, the Court has often held, and recently eloquently reaffirmed that if the objective of a law is to "'protect' members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior, the objective itself is illegitimate." Mississippi University for Women v. Hogan, 50 U.S.L.W. 5068, 5070 (1982). In a world in which no state "protects"

its citizens from unwisely choosing outpatient medical services, the special "protection", which the second trimester requirements provide exclusively for women seeking abortions, reflect and reinforce the assumption that women are "innately inferior" in their capacity to make appropriate medical decisions, in consultation with their physician. The lack of medical justification for the flat requirement that second trimester abortions be performed in the hospital[19/] simply confirms that the

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19 Planned Parenthood, et. al. v. Ashcroft, 664 F.2d 687 (8th Cir. 1981) reviews the data and concludes that the hospitalization requirement for second trimester abortions under-

(Footnote continues on following page)

purposes of these policies are to reinforce the stereotype of women as people who suffer from an "inherent handicap," and to force them to fulfill their "paramount destiny" as mothers.

(Footnote continued from preceding page)

mines women's health interest. The Sixth Circuit in Akron Center, etc. v. City of Akron, 651 F.2d 1198, found that evidence established the safety of outpatient procedures in the second trimester, and that the hospitalization requirement placed a significant burden on access to abortion, but nonetheless believed that this Court's summary affirmance of Gary-Northwest Indiana Women's Services v. Bowen, 451 U.S. 934 (1981) precluded a finding that the burdensome requirement was unconstitutional. See also Margaret S. v. Edwards, 488 F.Supp. 181, 193 (E. D.La. 1980), striking a hospitalization requirement as detrimental to women's health.

CONCLUSION

For the reasons stated above, amici respectfully submit that the judgment of the Eighth Circuit Court of Appeals should be affirmed, the judgment of the Sixth Circuit Court of Appeals should be affirmed in all respects except its holding that the constitutionality of the hospitalization requirement was forclosed by this court, and the judgment of the Supreme Court of Virginia should be reversed.

Respectfully submitted,

NADINE TAUB
15 Washington St.
Newark, N.J.

SYLVIA A. LAW
40 Washington Sq. So.
New York, N.Y. 10012

ELLEN J. WINNER
Rabinowitz, Boudin, Standard
Krinsky and Leiberman
30 East 42nd Street
New York, N.Y. 10017

Counsel gratefully acknowledge the assistance of Nancy Miller and Vicki Van Fleet.

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In the Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH INC., et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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BRIEF AMICUS CURIAE OF FEMINISTS FOR LIFE IN SUPPORT OF PETITIONER, CITY OF AKRON

DOLORES V. HORAN
180 N. LaSalle #1601
Chicago, IL 60601
(312) 822-4554
Attorney for Feminists for Life

Of Counsel:
Americans United for Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, IL 60601
312/263-5029

UNITED STATES LAW PRINTING CO., CHICAGO, ILLINOIS 60618 (312) 525-8581

TABLE OF CONTENTS

	PAGE
Table of Authorities	iii
Interest of the Amicus	1
Summary of the Argument	2
Argument	5
I. Introduction	5
II. The Fundamental Right Recognized in *Roe* v. *Wade* Was The Right Of A Pregnant Woman To Decide Whether Or Not To Terminate Her Pregnancy; The Physician Can Claim No Right To Withhold Information Necesary To Her Informed Consent	7
III. Factual Information Which Promotes An Intelligent, Knowing And Voluntary Decision By A Pregnant Woman Enhances That Woman's Ability To Exercise Her Fundamental Right To Decide Whether Or Not To Terminate Her Pregnancy	10
IV. The State May Legitimately Require That A Woman Be Given Sufficient Information To Enable Her To Decide Intelligently, Knowingly And Voluntarily Whether Or Not To Terminate Her Pregnancy	16
A. The State Has Not Only the Power But a Duty to Protect the Fundamental Rights of Its Citizens	16
B. Requiring That the Doctor Give Supplementary Factual Information When Counseling a Woman Does Not "Straightjacket" Him In the Practice of His Profession	20

PAGE

V. Lower Court Decisions Which Have Invalidated Informed Consent Provisions Are Inconsistent With The Decisions Of This Court 22

VI. A Short Mandatory Waiting Period Enhances The Woman's Ability To Decide By Allowing Her Time To Evaluate Information Which She Has Been Given 25

VII Even If Strict Scrutiny Were Applied, The State's Compelling Interest In Assuring The Integrity Of The Woman's Decision Would Justify Its Regulations Which Are Narrowly Drawn To Further That Interest 27

A. The State has a Compelling Interest in Assuring that the Woman's Decision Is Made Intelligently, Knowingly and Voluntarily 27

B. These Informed Consent Provisions Further the State's Compelling Interest and are Narrowly Drawn 28

VIII. Conclusion 29

Appendix ..... App. 1

TABLE OF AUTHORITIES

Cases

PAGE

Adams v. U.S. ex rel. McCann, 317 U.S. 269 (1942) 28

Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd 651 F.2d 1198 (6th Cir. 1981) 25

Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981) 8, 10, 18

Barsky v. Board of Regents of University of State of N.Y., 347 U.S. 442 (1954) 17

Bellotti v. Baird, 443 U.S. 622 (1979) (Bellotti II) 24, 26

Carnley v. Cochran, 369 U.S. 506 (1962) 28

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) ..8, 10, 12, 18

Doe v. Bolton, 410 U.S. 179 (1973) 3, 18

Eisenstadt v. Baird, 405 U.S. 438 (1972) 7

Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978), aff'd 440 U.S. 941 (1979) 15, 22

H. L. v. Matheson, 450 U.S. 398 (1981) 26

Harris v. McRae, 448 U.S. 297 (1980) 8, 11, 14, 15, 24

Hodgson v. Minnesota, No. 3-81 Civ. 538 (D. Minn., Mar. 23, 1982) (order granting preliminary injunction in part) 26

Maher v. Roe, 432 U.S. 464 (1977) 14, 27

Miranda v. Arizona, 384 U.S. 436 (1966) 28

Planned Parenthood v. Bellotti, 641 F.2d 1006 (1st Cir. 1981) 10, 11, 15, 25

PAGE

Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52 (1976) 8, 13, 20, 22, 23, 24

Planned Parenthood Association v. Fitzpatrick, 410 F.Supp. 554 (E.D. Pa. 1975), aff'd 428 U.S. 901 (1976) 22, 24, 25

Planned Parenthood Association of Kansas City, Mo., v. Ashcroft, 655 F.2d 848 (8th Cir. 1981) 8, 18

Planned Parenthood League v. Bellotti, 499 F.Supp. 215 (D. Mass.), aff'd in part, vacated in part 641 F.2d 1006 (1980) 10, 11, 20, 25

In the Matter of R.M.J., 102 S.Ct. 929 (Jan. 25, 1982) .. 21

Roe v. Wade, 410 U.S. 113 (1973) ..3, 6, 7, 8, 9, 14, 17, 18, 23

Virginia Pharmacy Board v. Virginia Citizens Consumer Council, 425 U.S. 748 (1976) 18, 19

Whalen v. Roe, 429 U.S. 589 (1977) 7, 9, 18

STATUTES & ORDINANCES

Akron, Ohio, Ordinance No. 160, chap. 1870.06(C) 21

Del. Code Ann. tit. 24 §1794 (Supp. 1980) ..... App. 1

Fla. Stat. §390.025(2) (Supp. 1981) ..... App. 2

Idaho Code §18-609(1) (Supp. 1981) ..... App. 2

Ill. Rev. Stat. ch. 38, §81-23.2 (1981) ..... App. 3, 6

Ill. Rev. Stat. ch. 40, §207 (1981) 26

Ill. Rev. Stat. ch. 40, §1511 (1981) 26

"Kentucky Abortion Act of 1982" March 17, 1982 Ky. Acts §311.4 ..... App. 7

"Kentucky Abortion Act of 1982" March 17, 1982 Ky. Acts §311.5 ..... App. 9

PAGE

La. Rev. Stat. Ann. §40:1299.35.6 (West Supp. 1981) App.10

Me. Rev. Stat. Ann. tit. 22, §1599 (Supp. 1981) .....App. 12

Md. Ann. Code art. 43, §138 (1980) .....App. 13

Mass. Ann. Laws ch. 112, §125 (Michie/Law, Co-op. Supp. 1982) .....App. 15

Minn. Stat. Ann. §145.412(1)(4) (West Cum. Supp. 1981) .....App. 17

Mo. Ann. Stat. §188.039 (Vernon Supp. 1982) .....App. 18

Mont. Code Ann. §50-20-104(3) (1981) .....App. 19

Mont. Code Ann. §50-20-106 (1981) .....App. 20

Neb. Rev. Stat. §28-326 (1981) .....App. 21

Neb. Rev. Stat. §28-327 (1981) .....App. 21

Nev. Rev. Stat. §442.253 (1981) .....App. 22

N.D. Cent. Code §14-02.1-02(5) (1981) .....App. 23

Ohio Rev. Code Ann. §2919.12(A) (Page 1982) .....App. 25

Ohio Rev. Code Ann. §3107.8 (Page 1982) 26

Okla. Stat. Ann. tit. 63, §1-736 (West Supp. 1981-1982) .....App. 25

Pa. Act of June 15, 1982, Pa. Laws .....App. 26

R.I. Gen. Laws §23-4.7-2 (1980) .....App. 28

R.I. Gen. Laws §23-4.7-4 (1980) .....App. 30

S.D. Codified Laws Ann. §34-23A-10 (1977) .....App. 30

S.D. Codified Laws Ann. §34-23A-10.1 (Supp. 1981) App. 30

Tenn. Code Ann. §39-302 (Supp. 1981) .....App. 31

Utah Code Ann. §76-7-305 (1979) .....App. 35

PAGE

Utah Code Ann. §76-7-305.5 (Supp. 1981) ..... App. 35

Va. Code §18.2-76 (1982) ..... App. 37

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Fed. R. Crim. Proc. Rule 11 28

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CITY OF AKRON,

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Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF AMICUS CURIAE OF FEMINISTS FOR LIFE IN SUPPORT OF PETITIONER, CITY OF AKRON

INTEREST OF THE AMICUS

Feminists for Life is a national organization with several state chapters. It was founded in 1972 by pro-life feminists to be a source of education and support for women. Its members reject a feminism which is materialistic and narcissistic and embrace a loving, nurturing posture of non-violence in relating to all members of the human family—including the unborn. The national office of Feminists for Life is located in Milwaukee, Wisconsin.

The officers of Feminists for Life include the following:

President
PAULINE M. CIRA

Vice-President
MARY LEDBETTER

Secretary-Treasurer
SHARON RICHARDSON

Newsletter Coordinator
MARY BEA STOUT

This brief is filed in support of Petitioner City of Akron. Letters of consent for the filing of this brief have been sent to this Court by both the Petitioners and Respondent.

SUMMARY OF THE ARGUMENT

Most abortions are performed at abortion clinics. Recent exposés of clinic practices have revealed widespread abuses in counseling. Essential information is often withheld from women, or misleading and inaccurate information disseminated.

Twenty-four of the 50 states have enacted corrective legislation in the form of abortion informed consent statutes. These statutes typically require that a minimum level of essential factual information be provided to pregnant women considering abortions so that they may, in a meaningful manner, exercise their fundamental right to decide whether or not to terminate their pregnancy. Three general categories of information are included in the typical informed consent statute: information on particular risks associated with the abortion procedure to be performed, information on agencies available to assist women during and after pregnancy, and information on fetal development. Many statutes also provide for a short mandatory waiting period to allow the woman to evaluate and reflect upon the information which she has been given.

Factual information of this kind unquestionably enhances the woman's ability to decide knowingly. It may also protect her from severe psychological trauma which she may experience upon later discovery of that information. Because this information does not burden the woman's decision-making capability, it is subject to rational basis review rather than strict scrutiny.

The promotion of irrational decisions constitutes the sole reasonable possibility of a "burden" in the context of informed consent provisions. Of course, the state may not attempt to require false, misleading or confusing information since such information would not further the state's legitimate interest in assuring the integrity of the woman's decision.

Several lower courts have placed the doctor on a pedestal and have given him broad discretion to withhold any information which he feels the woman should not have. These courts have invalidated informed consent statutes which require that specific factual information be given solely because the doctor believes such information should be withheld from the woman.

This Court never intended such a result. In *Roe* v. *Wade* and *Doe* v. *Bolton*, the Court prohibited the state from regulating doctors only in ways which *burden* the woman's fundamental right to decide. It is impossible for the state to burden the woman's right to decide by requiring that she be given factual information which, in fact, *enhances* her ability to decide. Thus, the state may require that the doctor give the woman factual information which enables her to make a knowing, intelligent and voluntary decision. The state has a duty to protect its pregnant citizens from the "paternalistic" attempts of doctors to keep them in ignorance. Through its licensing procedures, the state has empowered physicians to give professional advice on the advisability of an abortion. Having placed the physician in this position of responsibility, the state has the power and duty to correct his actions when they are irresponsible.

This Court has only ruled on the constitutionality of abortion informed consent provisions in three cases. Those decisions indicate that the rational basis test is appropriate. However, the lower courts have routinely applied strict scrutiny to these provisions. This is an inappropriate standard because such provisions do not burden the woman's right to decide.

The right of a pregnant woman to decide the outcome of her pregnancy encompasses two distinct fundamental rights: 1) the right to terminate her pregnancy, and 2) the right to bear her child. Therefore, in exercising one

of these fundamental rights, a woman necessarily waives another fundamental right of equal importance. The state has a compelling interest in ensuring that such an important decision is made knowingly, intelligently and voluntarily.

The state ned not fine-tune its statutes so as to facilitate abortions. Although some women may already know of this information, it would be impossible for the state to determine beforehand which women would be benefitted by this information and which would not. Thus, the statutes are narrowly drawn to serve the state's compelling interest in assuring that the woman's decision is made knowingly, intelligently and voluntarily.

ARGUMENT

I.

INTRODUCTION

The purpose of this brief is to explore the constitutional aspects of state abortion informed consent legislation—legislation which is intended to insure the integrity of the woman's decision-making process prior to abortion.

At present, 24 of the 50 states have enacted legislation which requires that women be provided with certain information prior to undergoing an abortion. *See generally*, Appendix.

Nineteen states specifically provide that the woman must be given information on the medical risks of abortion.* Eighteen states require that the woman be apprised of the alternatives to abortion,** and several require that she be informed of the identity of agencies that would assist her to carry her child to term. Thirteen states require that the woman be informed of the characteristics of the fetus at the time the abortion is contemplated.*** At least 11 states mandate that some period of time elapse between the time when information is provided and the time when the abortion is performed.****

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* Delaware, Idaho, Illinois, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, Rhode Island, Tennessee, Utah, and Virginia.

** Delaware, Florida, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, and Utah.

*** Delaware, Idaho, Illinois, Kentucky, Louisiana, Massachusetts, Missouri, Montana, North Dakota, Oklahoma, Rhode Island, South Dakota, and Utah.

**** Delaware, Illinois, Kentucky, Maine, Massachusetts, Missouri, Nebraska, Pennsylvania, South Dakota, Tennessee, and Utah.

It is apparent that in the ten years that have elapsed since this Court's decision in *Roe* v. *Wade*, 410 U.S. 113 (1973), many states have felt a compelling need to assure the integrity of the woman's abortion decision-making process.

Although varied in form, the informed consent laws are a clear manifestation of a specific legislative concern: that women contemplating a decision involving termination of fetal life and waiver of their fundamental right to continued childbearing should be provided with information that would permit them to make their decisions in a voluntary, knowing and intelligent fashion.

These states have adjudged that, in the absence of such legislation, the woman's right to make an informed abortion decision is not adequately protected. Present abortion practice militates against providing the woman with the full information she requires to make a competent abortion decision. This circumstance may be attributed to at least two causes: the strong economic impetus to persuade women to submit to abortion that naturally occurs in the clinic that relies exclusively on performing abortions in order to survive as a business entity and the impersonal, assembly-line fashion in which most abortions are performed.

Whatever the reasons, it is evident that legislatures in nearly half of the states have expressed an interest in assuring the integrity of the woman's abortion decision compelling enough to move them, in a very short period of time, to enact legislation in this area.

Such legislation should not be judged by this Court in the same manner as laws that effectively inhibit or prohibit effectuation of abortion decisions. In a technical sense, abortion informed consent laws may "impact" upon the right to decide whether or not to abort. But they *enhance*,

rather than vitiate the decision-making process of the woman, at least insofar as they provide objective information that may materially effect the outcome of the woman's decision. For this reason, such legislation should not be deemed inherently "suspect" and, thus, subject to strict judicial scrutiny. The various provisions of informed consent statutes should be sustained if they are relevant to the outcome of the pregnant woman's decision and reasonably promote an intelligent, knowing and voluntary decision.

II.

THE FUNDAMENTAL RIGHT RECOGNIZED IN ROE v. WADE WAS THE RIGHT OF A PREGNANT WOMAN TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY; THE PHYSICIAN CAN CLAIM NO RIGHT TO WITHHOLD INFORMATION NECESSARY TO HER INFORMED CONSENT.

Although the right of privacy is not explicitly mentioned in the Constitution, this Court has recognized a limited right of personal privacy which is secured by the Fourteenth Amendment. This right of personal privacy includes "the interest in *independence* in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977) (emphasis added). In *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972), this Court stated:

> If the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

Id. at 453 (emphasis in original).

Similarly, *Roe* v. *Wade* held that the Constitution protects "a *woman's decision* whether or not to terminate

her pregnancy." 410 U.S. at 153 (emphasis added). *See also Harris* v. *McRae*, 448 U.S. 297, 315 (1980) (constitutional right recognized in *Roe* was woman's freedom of choice).

In making her decision whether or not to terminate her pregnancy, a woman may consult such individuals as her spouse, parents or physician. Yet, whatever interests other individuals may have, it is clear that they do not possess the right to make the woman's decision for her. The only right which this Court recognized in *Roe* to be constitutionally protected was the *woman's* right to decide. This Court has consistently invalidated every attempt by a state to vest the decision in a party other than the pregnant woman when she is competent to decide for herself. *See, e.g., Planned Parenthood of Central Mo.* v. *Danforth*, 428 U.S. 52, 67-75 (1976) (spousal and parental consent invalidated).

Implicit in challenges to the various informed consent provisions which have been enacted is the theory that the *woman's* right to decide is somehow burdened by statutory schemes that do not permit the aborting *physician* to withhold certain information which he believes would "disturb" the woman, would make it less likely that the woman would choose abortion, or would complicate the physician's task of performing the abortion. *See, e.g., Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft*, 655 F.2d 848 (8th Cir. 1981) (state may not interfere with the judgment and advice of the doctor); *Charles* v. *Carey*, 627 F.2d 772 (7th Cir. 1980) (state must allow doctor to withhold any information, if the doctor feels that that information may distress the woman or cause her to forego an abortion); *Akron Center for Reproductive Health* v. *City of Akron*, 651 F.2d 1198, 1207 (6th Cir. 1981) (informed consent provisions were unconstitutional because they "imping[e] on the medical judgment of the attending pjhysician" by "re-

quir[ing] the doctor to make certain disclosures in all cases, regardless of his own professional judgment as to the desirability of doing so").

According to this line of reasoning, statutory shemes which require that the physician provide all women with certain information are, in effect, unconstitutionally overbroad because they do not permit the physician to withhold information from women according to his "medical judgment."

This theory is inherently defective, however, because the right acknowledged in *Roe* is exclusively the right of the woman to decide whether or not to terminate pregnancy. The Constitution does not vest the physician with the paternalistic authority to withhold information that may be otherwise material to the outcome of a woman's abortion decision.

Expansion of the right of privacy recognized in *Roe* to include a right of a physician to, in effect, exercise the woman's fundamental right to decide for her as though she were an incompetent must not be tolerated by this Court. The physician can no more claim that the Constitution grants him a "right" to withhold information from a woman that may be necessary to her competent and independent abortion decision than a husband or parent can claim a "right" to deny the woman the power to effectuate the abortion decision.

As this Court has held, any "right" the physician might claim in this area derives solely from the *woman's* right to decide whether or not to terminate pregnancy. *Whalen* v. *Roe*, 429 U.S. 589 (1977). Informed consent statutes which provide women with information that would assist them to make a rational abortion decision enhance, rather

than burden, the woman's freedom of choice. Since the woman's right is not burdened by informed consent provisions, the physician can claim no derivative right to withhold such information from her.

III.

FACTUAL INFORMATION WHICH PROMOTES AN INTELLIGENT, KNOWING AND VOLUNTARY DECISION BY A PREGNANT WOMAN ENHANCES THAT WOMAN'S ABILITY TO EXERCISE HER FUNDAMENTAL RIGHT TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY.

Factual information which is relevant to the outcome of the woman's decision and reasonably promotes an intelligent, knowing and voluntary decision enhances the woman's ability to exercise her fundamental right to decide.

The Court of Appeals for the First Circuit correctly noted in *Planned Parenthood* v. *Bellotti,* 641 F.2d 1006, 1019 (1st Cir. 1981), that "the promotion of irrational decisions constitutes the sole reasonable possibility of a burden" in the context of informed consent provisions.

In spite of this rather obvious fact, several lower courts have routinely invalidated informed consent provisions requiring that factual information be given to the woman.

The Sixth Circuit invalidated all those provisions of the Akron informed consent provision which required that specific factual information be supplied to the woman. *Akron Center for Reproductive Health* v. *City of Akron,* 651 F.2d 1198, 1206-1208 (6th Cir. 1981). Other circuits have approached such requirements in a piecemeal fashion. In *Charles* v. *Carey,* 627 F.2d 772, 783-784 (7th Cir. 1980), for example, the court struck information on fetal development, while sustaining information on abortion risks and

alternatives. It was not the court's intention to confine itself to upholding purely medical information pertaining to maternal health risks, for it upheld the requirement that the woman be provided with a list of abortion alternatives agencies. Yet the court also struck non-medical information on fetal development. In a similarly arbitrary fashion, the court of appeals in *Planned Parenthood* v. *Bellotti*, 641 F.2d 1006, 1016-1022 (1st Cir. 1981), upheld provisions for risks and abortion alternatives information, yet struck the requirement that the women be given information on fetal development.

There appears to be no logical basis for the distinctions drawn by the lower courts between the kinds of information offered to the woman. Information on fetal development, for example, may be no more or less "disturbing" than information on some of the serious medical risks that may attend abortion. But at least one court has held that information on fetal development, no matter how innocuous and objective, must be excluded from informed consent legislation while also holding that information on medical risks, no matter how potentially serious or troubling to the woman, might be included. *Planned Parenthood* v. *Bellotti*, 641 F.2d at 1016-1022. On what constitutionally cognizable basis can one sort of information be deemed permissible, but the other utterly impermissible?

Information on fetal development may lie at the heart of the woman's decision. It is the very existence of the fetus which has necessitated the choice, and it is the purposeful termination of that fetal life which makes the abortion decision uniquely stressful. *Harris* v. *McRae*, 448 U.S. 297, 325 (1980). It is difficult to see how a woman can make an informed abortion decision if she is unaware of the nature of fetal development.

In addition to enabling the woman to make a meaningful choice, information on fetal development may protect her

from the trauma which she may later experience because of an improvident and uninformed decision in this regard. It is evident that many women are unaware of the degree of fetal development at the time of their abortion, and that they would not have had an abortion had they been aware of this information. These women could be spared the severe guilt and trauma which they will later experience upon discovering this information. For example, in her Affidavit, in *Charles* v. *Carey*, No. 79-C-4541 (N.D. Ill., filed July 9, 1982), Cindy Lietz stated:

> The entire counseling session was very impersonal. We were given a brief explanation of the abortion procedure and birth control. At no point were we told of the maturity or growth of our unborn child and no mention was ever made of anything alive within us. The fetus was always referred to as the "contents of the uterus."

Id. at para. 7.

> It seemed to me that the personnel at the clinic treated us as if we all had our minds made up to have an abortion. Had I been given any information on the stage of development of my unborn baby, I would not have consented to the abortion. Such information would have impressed upon me the true nature of my child. It was not simply "contents of the uterus." It was already alive and developing and I was left in ignorance of that fact. Someone should have told me what my unborn baby was like and then let me make an educated decision about whether or not I wanted the abortion. Keeping me in ignorance like that made me do something which I have regretted to this day. I believe that those people at the clinic took advantage of our vulnerability in such a delicate situation.

Id. at para. 9.

> After the abortion I started reading books on fetal development. I discovered information that I did not know before the abortion. I learned that at ten weeks

> duration (the stage at which my pregnancy was aborted) my baby had eyes and ears, a beating heart, little lung buds, a spinal cord, nerves and blood vessels, cartilage, arms and legs with little fingers and toes starting to appear. If the doctor had explained to me the degree to which my unborn child was developed, I would have walked right out of the clinic.

Id. at para. 14.

> Until I read about fetal development on my own, I didn't really know what I had let them do to me. I was horrified when I realized what had happened. The abortion changed my life and nearly destroyed me.

Id. at para. 16.

Factual information on fetal development, alternatives agencies, and risks associated with the abortion procedure unquestionably enhances the woman's decision-making authority. It does not burden her decision-making capability and is subject only to rational basis review, not strict scrutiny.

To treat informed consent provisions in the same manner as provisions which burden the woman's right to decide would contravene this Court's decision in *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U.S. 52, 90 (1976) (Stewart and Powell, JJ., concurring) (informed consent provisions "aimed at ensuring that the abortion decision is made in a knowing, intelligent and voluntary fashion" may be treated differently from "state law[s] aimed at thwarting a woman's decision to have an abortion").

Lower courts which have invalidated such provisions as somehow "burdensome" have adopted an untenable position. Factual information of this kind can be said to burden a woman's ability to make a rational choice only if one presumes that abortion is the only rational choice which a pregnant woman could make. Under such a pre-

sumption, any information which makes the woman's decision more difficult or leads her to forego an abortion altogether would constitute a "burden" on her ability to make a "rational" choice.

Once again, this line of reasoning misconceives the nature of the fundamental right recognized in *Roe* v. *Wade*. *See Maher* v. *Roe*, 432 U.S. 464, 473-474 (1977). The right protected is the "woman's right to decide whether *or not* to terminate her pregnancy." *Roe* v. *Wade*, 410 U.S. 113, 153 (1973) (emphasis added). The woman need not choose to abort in order to have exercised her fundamental right to decide. Rather, the successful exercise of this right depends on the extent to which the woman possesses sufficient information to make an informed choice between two alternatives of great consequence: carrying her child to term or terminating her pregnancy.

This overreaching by the lower courts is not to be tolerated. It infringes on the legislative prerogative of the states and forces them to stand idly by while their citizens are subjected to an abusive practice by which material information is withheld from women during their abortion decision-making process. Moreover, such an arbitrary and capricious posture toward the elements of informed consent legislation suggests a non-neutral stance on the part of the judiciary in favor of abortion. As this Court held in *Harris* v. *McRae*,

> It is not the mission of this Court or any other to decide whether the balance of competing interests reflected [in legislation] is wise social policy . . . [w]e cannot, in the name of the Constitution, overturn duly enacted statutes simply "because they may be unwise, improvident, or out of harmony with a particular school of thought." Rather, "when an issue involves

> policy choices as sensitive as those implicated [here] . . . , the appropriate forum for their resolution in a democracy is the legislature.

448 U.S. 297, 326 (1980) (citations omitted).

Of course, false, misleading or confusing information would not promote an intelligent, rational decision. Such information is not reasonably related to the state's legitimate interest in assuring the integrity of the woman's abortion decision and might properly be stricken. *Freiman* v. *Ashcroft*, 584 F.2d 247, 257 (8th Cir. 1978), *aff'd.* 440 U.S. 941 (1979) ("meaningless" information is "not reasonably related to the purpose of informed consent").

Likewise, it is conceivable that information which is highly emotionally charged and designed to bias the woman's decision may detract from her rational decision-making ability. As the court of appeals in *Planned Parenthood* v. *Bellotti* suggested, the familiar probative/prejudicial standard of the Federal Rules of Evidence is a useful tool for determining whether a challenged provision promotes a rational decision and is, therefore, reasonably related to the state's important interest in assuring the integrity of the woman's decision. Under this test, for example, a state could be prevented from requiring that a woman be shown gory pictures of aborted fetuses, as opposed to being provided with an objective and scientifically accurate description of fetal development, since the former would not further a rational decision. Similarly, excessive amounts of information which, although relevant and probative, is merely cumulative could not be required under this test.

It must be concluded that any element in abortion informed consent legislation that would materially affect the outcome of the woman's decision without being merely inflammatory or cumulative enhances, rather than burdens, the woman's decision-making ability. As such, abortion

informed consent legislation must not be subjected to strict judicial scrutiny—each element in such legislation must be upheld if it materially contributes to the rational decision-making process of the woman.

IV.

THE STATE MAY LEGITIMATELY REQUIRE THAT A WOMAN BE GIVEN SUFFICIENT INFORMATION TO ENABLE HER TO DECIDE INTELLIGENTLY, KNOWINGLY AND VOLUNTARILY WHETHER OR NOT TO TERMINATE HER PREGNANCY.

A. The State Has Not Only the Power But a Duty to Protect the Fundamental Rights of Its Citizens.

Through its licensing procedures the state empowers physicians to give professional advice to pregnant women on the advisability of undergoing an abortion. Having placed the physicians in this position of responsibility, the state has not only the power but a duty to protect its citizens by ensuring that these physicians act responsibly.

Recent exposés of widespread abuses regarding either 1) the total withholding of essential information, or 2) the dissemination of misleading or inaccurate information, have prompted several legislatures to enact corrective legislation in the form of informed consent provisions. The comments of State Representative Kelly, sponsor of the Illinois abortion informed consent law, are illustrative of these concerns:

> As the *Sun Times** series noted, most abortion clinics provide little or no counseling to women about to un-

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* This series, entitled *The Abortion Profiteers*, reported the results of a five month undercover investigation of Chicago abortion clinics which was conducted in cooperation with the Better Government Association. Pamela Zekman received a Pulitzer Prize for her investigative reporting in this series.

> dergo a potentially damaging operation. There is usually no time for women to express concern they may have about the abortion procedure. Counseling for patients at the present time is left to the discretion of the abortion clinic director. The doctor need not be involved. One under-cover investigator for the *Chicago Sun-Times* series, Michele Young, was trained at the Biogenetics Clinic not to counsel. She reported that she was told not to tell patients the abortion procedure might hurt. Not to discuss the abortion procedure or its surgical instruments in any detail and not to answer to many questions. The clear implication is that the less the patient knows, the easier it will be to sell her a medical procedure she may not want or need and which may be harmful to her. The Informed Consent Provisions of Senate Bill 47 [Ill. Rev. Stat. ch. 38, 81-23.2 (1981)] are an attempt to redress the almost complete lack of adequate counseling. . . . We must be sure through provision of state provided material that would-be abortion patients are provided with complete, accurate, and free information. . . .
>
> The *Chicago Sun-Times* series has shown us too much of the abuse that results from allowing clinic personnel or abortionists to counsel the women as they please because more often than not, they do nothing.

Illinois General Assembly, House Debates, comments of House Sponsor, Rep. Richard Kelly.

The Constitution does not prevent a state from protecting its citizens by reasonably regulating the practices of the medical profession. Nor do the decisions of this Court indicate otherwise. *See, e.g., Barsky* v. *Board of Regents,* 347 U.S. 442 (1954).

Yet several lower courts have read this Court's decision in *Roe* v. *Wade* to give nearly unfettered discretion to the doctor in consulting with and advising the pregnant woman

on abortion. *See Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft,* 655 F.2d 848 (8th Cir. 1981); *Akron Center for Reproductive Health* v. *City of Akron,* 651 F.2d 1198 (6th Cir. 1981); *Charles* v. *Carey,* 627 F.2d 772 (7th Cir. 1980).

Clearly this Court never intended such a result. In *Roe* and *Doe,* the Court prohibited the state from regulating doctors only in ways which *burden* the woman's fundamental right to decide. Justice Stevens emphasized that point in *Whalen* v. *Roe,* 429 U.S. 589 (1977). Writing for a unanimous Court, he stated:

> The constitutional right vindicated in *Doe* was the right of a pregnant woman to decide whether or not to bear a child without unwarranted state interference. The statutory restrictions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision. If those obstacles had not impacted upon the woman's freedom to make a constitutionally protected decision, if they had merely made the physician's work more laborious or less independent without any impact on the patient, they would not have violated the Constitution.

Id. at 605 n.33.

In *Virginia Pharmacy Board* v. *Virginia Citizens Consumer Council,* 425 U.S. 748 (1976), the state of Virginia sought to keep certain pricing information from being disseminated. It claimed that this was a permissible means of protecting its citizens. In rejecting the state's arguments, the Court stated that "the State's protectiveness of its citizens rests in large measure on the advantages of their being kept in ignorance." *Id.* at 769. The Court continued, stating that there is

> [a]n alternative to this highly paternalistic approach. That alternative is to assume that this information is not in itself harmful, that people will perceive their own best interests if only they are well-enough informed, and that the best means to that end is to open the channels of communication rather than close them.

Id. at 770.

Doctors challenging informed consent provisons for prospective abortion patients have claimed that they may protect their patients' best interests by withholding information, no matter how important it is to each woman's decision.* Like the state's paternalism in *Virginia Pharmacy Board,* the doctor's paternalism in this context rests on the supposed advantages of keeping the potential listener in ignorance. As in *Virginia Pharmacy Board,* there is a better alternative to this approach: to assume that factual information is not in itself harmful and that women will perceive their own best interests if only they are well-enough informed.

According to *Virginia Pharmacy Board,* the state clearly could not withhold factual information from women which is essential to their informed decisions in an attempt to shield them from the truth. Since a doctor is a professional, licensed by the state and designated by the state as a party in his or her patients' decision-making processes it follows that the state has the power, if not the duty, to ensure that the doctor does not withhold information material to the outcome of the abortion decision-making process.

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* Doctors at abortion clinics, where the vast majority of abortions are performed, rarely see their patients before they are on the operating table. These doctors do not personally counsel their patients. Any claim that they would withhold information based on their "best medical judgment" after consideration of their patient's "best interests" is, therefore, disingenuous.

B. Requiring That the Doctor Give Supplementary Factual Information When Counseling a Woman Does Not "Straightjacket" Him In the Practice of His Profession.

The trial records of several cases show that information on fetal development is rarely given to women. In *Planned Parenthood League* v. *Bellotti,* 499 F.Supp. 215, 219 (D.Mass. 1980), for example, the court found that "the clinics and counselors avoid discussion of the state of [fetal] development. . . . One counselor states that she would make every effort to avoid telling the patient about the physical characteristics of the embryo." *See also Planned Parenthood* v. *Danforth,* 428 U.S. 52, 91 n. 2 (1976) (Stewart, J., concurring). Indeed, "counselors" have adopted several euphemistic terms such as "products of conception," "fetal tissue" or "contents of the uterus" to describe the developing fetus.

> For example, in their efforts to discount the value of, or need for this type of information, the plaintiffs' evidence describes the 8 week old embryo as a largely undifferentiated cell mass. (Dr. Emans' Affidavit, Pl. Ex. #10). But the Resource Manual (Pl. Ex. #3) describes and illustrates the 8 week old embyro as largely developed, with head, arms and legs.

Planned Parenthood League v. *Bellotti,* 499 F.Supp. at 219.

In view of such practices, the need for corrective legislation is apparent. It is difficult to imagine how a woman who believes that she is removing an "undifferentiated cell mass" can be aware of the significance of her decision when, in reality, she is causing the death of a "largely developed [embryo], with head, arms and legs."

Although a state may not prohibit a doctor from giving truthful information, it is certainly not prevented from correcting deceptive practices on his part.

This Court's decisions in the area of commercial speech are particularly pertinent here. While "truthful [information] related to the lawful activities" is entitled to First Amendment protection, "[f]alse, deceptive, or misleading [information] remains subject to restraint." *In the Matter of R.M.J.*, 102 S.Ct. 929, 936 (1982). This is especially true in the case of information disseminated by professionals—in this case, doctors. Such information "poses special risks of deception" since the patient's comparative lack of knowledge makes it likely that she will accept the doctor's description as entirely accurate. *Id.* Minors, who account for approximately one-third of abortions performed each year, are especially susceptible in this regard.

Because of the great potential for deception associated with information disseminated by professionals, and the "limited ability of the professions to police themselves," the state has a legitimate and compelling interest in regulating the content of their speech in a manner which prevents such abuses.* *Id.* at 937.

This is especially true in the abortion context, where the woman may be subject to special emotional stresses and where her decision involves waiver of her fundamental right to carry her child to term.

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* Informed consent provisions do not attempt to limit the doctor's comments about the state-required information. He is free, indeed encouraged, to say what he pleases in addition to the information he is required by law to provide to the woman. *See, e.g.*, Akron, Ohio, Ordinance Number 160 (1978); codified Chap. 1870.06(C).

V.

LOWER COURT DECISIONS WHICH HAVE INVALIDATED INFORMED CONSENT PROVISIONS ARE INCONSISTENT WITH THE DECISIONS OF THIS COURT.

The lower courts which have invalidated informed consent provisions have improperly applied strict scrutiny and required that the state show a compelling interest to justify such provisions.

This Court has ruled on the constitutionality of informed consent provisions in abortion statutes in three cases.

In *Planned Parenthood Association* v. *Fitzpatrick,* 410 F.Supp. 554, 587 (E.D. Pa. 1975), *aff'd sub nom. Franklin* v. *Fitzpatrick,* 428 U.S. 901 (1976), this Court adopted the rational basis test applied by the district court.

Although the court of appeals in *Freiman* v. *Ashcroft,* 584 F.2d 247 (8th Cir. 1978) *aff'd,* 440 U.S. 941 (1979), did not explicitly adopt a rational basis test, its decision is logically consistent with this level of scrutiny. While the court acknowledged the state's legitimate interest in protecting the woman by requiring informed consent, it stated that the Supreme Court does not require physicians to provide "any and all information required by the State, regardless of its legality, truth, constitutionality or medical advisability." 584 F.2d at 251. Since the information required in *Freiman* was "meaningless" and therefore confusing, the court held that it was "not reasonably related to the purpose of informed consent." *Id.* Thus, the information at issue was, in effect, deemed impermissible under the rational basis test.

In *Danforth,* this Court explicitly upheld an informed consent provision which required that a woman certify

"that her consent is informed and freely given and is not the result of coercion." 428 U.S. at 65. This Court held:

> The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned and her awareness of the decision and its significance may be assured, constitutionally, by the State.

428 U.S. at 67.

Some lower courts have made much of footnote 8 of *Danforth* which states:

> We are content to accept as the meaning [of informed consent] the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straightjacket in the practice of his profession.

Id. at 67 n.8.

This language has been interpreted by some courts to mean that only medical information may be required. Others have read it to broadly proscribe any action by the state which might "straightjacket" a doctor in the practice of his profession. Neither interpretation comports with this Court's holdings.

This Court has often recognized that the abortion decision and its consequences are not purely medical. In *Roe*, the Court stated:

> Maternity or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a

> family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

410 U.S. at 153. *See also Harris* v. *McRae,* 448 U.S. 297, 325 (1980) ("[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life"); *Bellotti* v. *Baird,* 443 U.S. 622, 649 ("[t]he abortion decision has implications far broader than those associated with most other kinds of medical treatment"); *Planned Parenthood* v. *Danforth,* 428 U.S. at 103 (Stevens, J., concurring) ("the most significant consequences of the decision are not medical in character").

Indeed, in *Franklin* v. *Fitzpatrick,* 428 U.S. 901 (1976), this Court summarily affirmed a lower court decision which upheld admittedly non-medical information regarding alternatives agencies. Thus, relevant non-medical information clearly may be required.

Moreover, footnote eight of *Danforth* was in response to a claim that "informed consent" was unconstitutionally vague. It was claimed that the Missouri informed consent provision did not give the physician sufficient notice of what he might be prosecuted for. To avoid this challenge, the Court construed "informed consent" to mean "just what would be done and . . . its consequences." 428 U.S. at 67 n.8.

Footnote 8 of *Danforth* does not announce a new principle of jurisprudence, as many lower courts have seemed to think, that the Constitution forbids physicians from being controlled in the practice of their profession.

This Court has, contrary to lower courts, applied principles consistent with the rational basis test to abortion informed consent statutes. That test should be applied in the instant case to the Akron informed consent provisions.

VI.

A SHORT MANDATORY WAITING PERIOD ENHANCES THE WOMAN'S ABILITY TO DECIDE BY ALLOWING HER TIME TO EVALUATE INFORMATION WHICH SHE HAS BEEN GIVEN.

In *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 479 F.Supp. 1172, 1204 (N.D. Ohio 1979). Judge Contie stated:

> Requiring a woman to wait 24 hours between signing the consent form and undergoing an abortion assertedly serves the state's interest in assuring that the abortion decision is made carefully after consideration of all the relevant facts. This is an important state interest considering the irreversible nature and possible lasting consequences of the abortion decision.

In *Planned Parenthood* v. *Bellotti*, 499 F.Supp. 215 (D. Mass. 1980), the district court held that "an informed decision cannot be properly made without sufficient time for reflection." *Id.* at 222. It found that a 24-hour delay was a reasonable amount of time to assure the state's interest in an informed decision. In general, "the abortion decision is somewhat hurriedly arrived at and executed." *Planned Parenthood Association* v. *Fitzpatrick*, 410 F. Supp. at 587. Information concerning alternative agencies and fetal development would have little effect unless the woman were given time to consider that information and to contact other agencies to learn what they have to offer.

Clearly, some waiting period must be permissible. Otherwise, the abortion clinic could merely provide the woman

with information necessary to informed consent while she was already on the operating table, thereby totally frustrating any expression the state's legitimate interest in assuring the integrity of the woman's decision.

Although the 24 hour delay may inconvenience a woman, it does not approach the degree of interference necessary to trigger strict scrutiny. This Court has already permitted similar delays in other cases. In *Bellotti* v. *Baird*, 443 U.S. 622, 643 (1979) (*Bellotti II*), this Court stated that where a state requires a pregnant minor to obtain parental consent, it must also provide for an alternative judicial hearing whereby authorization for the abortion may be obtained. Even expedited hearings would presumably cause delays of up to 24-48 hours. *See Hodgson* v. *Minnesota*, No. 3-81 Civ. 538, slip op. at 8, 9 (D. Minn. Mar. 23, 1982) (delay in most cases of 24-48 hours). *See also H. L.* v. *Matheson*, 450 U.S. 398 (1981) (reasonable attempts to notify parents of unemancipated immature minor's impending abortion may require at least a 24-hour delay).

States have traditionally ensured the integrity of their citizens' decisions by enforcing mandatory waiting periods. Several states do not consider a woman's consent to the adoption of her child to be valid if given within 72 hours of the child's birth. *See, e.g.*, Ill. Rev. Stat. ch. 40, §1511 (1981); Ohio Rev. Code Ann. §3107.8 (1980). Many states also protect the important decision to marry by requiring that 24 hours elapse between the time the marriage license is obtained and the time it becomes valid. *See, e.g.*, Ill. Rev. Stat. ch. 40, §207 (1981).

Both adoption and marriage decisions, like the decision to abort, implicate the exercise and waiver of fundamental rights. Just as the state might legitimately require a

reasonable waiting period before marriage or adoption, it may require a brief waiting period prior to abortion in order to assure the integrity of the woman's decision.

VII.

EVEN IF STRICT SCRUTINY WERE APPLIED, THE STATE'S COMPELLING INTEREST IN ASSURING THE INTEGRITY OF THE WOMAN'S DECISION WOULD JUSTIFY ITS REGULATIONS WHICH ARE NARROWLY DRAWN TO FURTHER THAT INTEREST.

Even if this Court should hold that abortion informed consent requirements somehow "burden" the right of the woman to decide whether or not to abort, they nevertheless must be upheld because they serve the state's compelling interest in ensuring the integrity of the woman's decision and are narrowly drawn to suit that interest.

1. The State Has a Compelling Interest in Assuring that the Woman's Decision Is Made Intelligently, Knowingly and Voluntarily.

The fundamental right of a pregnant woman to decide the outcome of her pregnancy encompasses two distinct fundamental rights: 1) the right to terminate her pregnancy, and 2) the right to bear her child. Therefore, in exercising one of these fundamental rights, a woman necessarily waives another fundamental right of equal importance. *Maher* v. *Roe*, 432 U.S. 464, 472 n. 7 (1977). The state, consistent with its duty to protect the fundamental rights of its citizens, has a compelling interest in ensuring

that such an important decision is made knowingly, intelligently and voluntarily.*

2. These Informed Consent Provisions Further the State's Compelling Interest and are Narrowly Drawn.

The informed consent provisions are narrowly drawn to serve only the state's interest in assuring that the woman's waiver of one of her contrasting fundamental rights is knowing, intelligent and voluntary. The provisions are designed to make the woman aware of the alternatives to and consequences of her waiver—precisely the information appropriate under the circumstances. The argument that such provisions are not narrowly drawn rests on the assumption that some individuals might already know the information. But if they already know, they can hardly be harmed by simply receiving duplicative information, and a concept of "narrowly drawn" that required a state to tailor its laws for each unique individual would make that requirement utterly incapable of fulfillment. It would be impossible for the state to know beforehand which women know this information and which do not.

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* *Compare Adams* v. *U.S. ex rel. McCan*, 317 U.S. 269 (1982) ("The fundamental right to assistance of counsel may be waived provided it is done so 'knowingly and intelligently.'") *Carnley* v. *Cochran*, 369 U.S. 506 (1962) (waiver is not to be lightly assumed; it must not be presumed from a silent record); *Miranda* v. *Arizona*, 384 U.S. 436 (1966) (circumstantial evidence of waiver will not suffice). *See also* Fed. R. Crim. Proc. Rule 11 (waiver of right to trial by jury may not be accepted by judge unless he is satisfied that it was made knowingly and intelligently).

VIII.

CONCLUSION

This Court should reverse the decision of the Sixth Circuit, which incorrectly decided the issue of informed consent, and should explicitly rule that informed consent provisions must be reviewed under the rational basis standard. The provisions of the Akron ordinance are constitutional because they are reasonably related to the City's legitimate interest in promoting a knowing, intelligent and voluntary decision. This Court should take this opportunity to explicitly state that informed consent provisions must be reviewed under a rational basis test.

Respectfully submitted,

DOLORES V. HORAN
180 N. LaSalle, #1601
Chicago, Illinois 60601
(312) 822-4554
Attorney for Amicus Curiae, Feminists for Life.

Of Counsel:
Americans United for Life
Legal Defense Fund
230 N. Michigan Avenue, #915
Chicago, Illinois 60601
(312) 263-5029

APPENDIX

ABORTION INFORMED CONSENT LAWS STATE-BY-STATE

1. Delaware

Del. Code Ann. tit. 24 §1794 (Supp. 1980).

Consent prior to termination of human pregnancy.

(a) No abortion may be performed unless the woman submitting to the abortion first gives her written consent to the abortion stating that she freely and voluntarily consents to the abortion and that she has received a full explanation of the abortion procedure and effects, including, but not limited to, the following:

(1) The abortion procedure to be utilized.

(2) The probable effects of the abortion procedure on the woman, including the effects on her child-bearing ability and effects on possible future pregnancies.

(3) The facts of fetal development as of the time the proposed abortion is to be performed.

(4) The risks attendant to the procedure.

(5) An explanation of the reasonable alternatives to abortion and of the reasonable alternative procedures or methods of abortion.

(b) No abortion may be performed on a woman within 24 hours after giving written consent pursuant to subsection (a) of this section unless, in the opinion of her treating physician, an emergency situation presenting substantial danger to the life of the woman exists.

In the event a woman's treating physician determines an abortion is necessary because an emergency situation presenting substantial danger to the life of the woman existed and such woman is unable to give her consent to an abortion, an abortion may be performed on such woman. (62 Del.Laws, c. 171, § 1.)

2. Florida

Fla. Stat. 390.025(2) (Supp. 1981).

(2)An abortion referral or counseling agency, before making a referral or aiding a person in obtaining an abortion, shall furnish such person with a full and detailed explanation of abortion, including the effects of and alternatives to abortion. If the person advised is a minor, a good faith effort shall be made by the referral or counseling agency to furnish such information to the parents or guardian of the minor . No abortion referral or counseling agency shall charge or accept any fee, kickback, or compensation of any nature from a physician, hospital, clinic, or other medical facility for referring a person thereto for an abortion.

3. Idaho

Idaho Code 18-609 (I) (Supp. 1982).

Physicians and hospitals not to incur civil liability—Consent to abortion—Notice.—(1) Any physician may perform an abortion not prohibited by this act and any hospital may provide facilities for such procedures without, in the absence of actual negligence, incurring civil liability therefor to any person, including but not limited to the pregnant woman and the prospective father of the fetus to have been born in the absence of abortion, if consent for such abortion has been duly given by the pregnant woman and, if she be

a married person at the time of conception or at any time during the pregnancy, and that fact is actually known by the physician, and if the said husband has not abandoned her, then by the said husband as well; provided that, in obtaining a valid consent for the performance of such an abortion, the physician shall not be required to possess or claim special expertise but shall, nonetheless, and in his best judgment, advise and counsel such pregnant woman or her husband regarding such matters as possible emotional or psychological consequences of the abortion, the probable health or characteristics of the child otherwise to be born of such pregnancy, the likelihood of such woman becoming pregnant again or of the husband or prospective father again fathering a child, and provided further, if the abortion be within the provisions of section 18-608(3), Idaho Code, and either the pregnant woman or the said husband be for any reason unavailable or unable to give a valid consent therefor, the requirement for that person's consent shall be met as provided by law for other medical or surgical procedures and shall be determined in consideration of the interests, wishes and welfare of the pregnant patient.

4. Illinois

Ill. Rev. Stat. ch. 38, 81-23.2 (1981).

§ 3.2. Informer Consent. (A) No abortion shall be performed except with the voluntary and informed consent of the woman upon whom the abortion is to be performed.

(1) Consent to an abortion is voluntary and informed if and only if:

(a) The woman is provided, at some time before the abortion, with a true copy of her preg-

nancy test result by the physician who is to perform the abortion and the woman is provided, at least 24 hours before the abortion, with the following information by the physician who is to perform the abortion:

(i) The name of the physician who will perform the abortion,

(ii) The particular medical risks associated with the particular abortion procedure to be employed,

(iii) The probable gestational age of the fetus at the time the abortion is to be performed, and

(iv) The printed information prescribed in Section 3.5 of this Law, and

(b) Prior to submitting to the abortion, but subsequent to receiving the information prescribed by paragraph (A)(1)(a) of Section 3.2, the woman certifies in writing that she has received that information from the physician at least 24 hours before the abortion is to be performed, that she understands it, that she consents to the abortion, and that her consent is voluntary and not the result of coercion.

(B) Exceptions.

(1) Waiver of waiting period. The requirement of paragraph (A)(1)(a) of Section 3.2 that at least 24 hours elapse between the provision of the information prescribed and the performance of the abortion shall not apply when, in the medical judgment of the attending physician based on the particular facts of the case before him, there exists a medical emergency which

warrants nullification of the 24 hour waiting period. In such a case, the physician shall describe the basis of his medical judgment that such an emergency exists on a form prescribed by the Department as required by Section 10 of this Law.

(2) Limitation of Informed Consent Requirements. Paragraph (A) of Section 3.2 shall not apply when, in the medical judgment of the attending physician based on the particular facts of the case before him, there exists a medical emergency which warrants nullification of the requirements that the woman be provided with the information prescribed by paragraph (A)(1)(a) of Section 3.2 and that the woman certify her consent as prescribed by paragraph (A)(1)(b) of Section 3.2. In such a case, the physician shall describe the basis of his medical judgment that such an emergency exists on a form prescribed by the Department as required by Section 10 of this Law and, if the woman survives the abortion, the physician shall subsequently inform her of the medical indications for his judgment that a medical emergency existed and of the particular medical risks associated with the particular abortion procedure employed the symptoms of which might become manifest in the future.

(C) Penalty. Any person who intentionally, knowingly or recklessly violates the requirements of Section 3.2 commits a Class B misdemeanor. Failure to provide the woman with information pursuant to the requirements of Section 3.2 is prima facie evidence of failure to obtain informed consent in appropriate civil actions. The law of this State shall not be construed to preclude award of exemplary damages in any appropriate civil action relevant to violations of Section 3.2.

Nothing in Section 3.2 shall be construed to limit the common law rights of the woman to secure informed consent to any form of medical treatment, including abortion.

§ 3.5. Printed Information. The Department shall, within 60 days after Section 3.5 becomes law, cause to be published printed materials that may be easily comprehended in all languages used by significant portions of the population of this State:

(1) Materials designed to inform concerned persons of public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while the child is dependent, including reputable adoption agencies. Such materials shall include a comprehensive list of the agencies available and a description of the manner in which they might be contacted, and

(2) Materials designed to inform concerned persons of the probable anatomical and physiological characteristics of the fetus at the various gestational ages at which abortion might be performed, including any relevant information on the possibility of fetal survival. The following paragraph shall appear at the end of the materials required under this paragraph (2) of Section 3.5:

The State of Illinois wants you to know that in its view the child you are carrying is a living human being whose life should be preserved. Illinois strongly encourages you not to have an abortion but to go through to childbirth. You are being given a list of agencies and services which can help you to continue the pregnancy, and assist you and your child after your child is born, whether you choose to keep your child or to

place her or him for adoption. The State of Illinois strongly encourages you to contact some of them before making a final decision about abortion.

The materials required by paragraph 2 of Section 3.5 shall occupy no more than 3 sheets of 8½" by 11" paper, and shall be printed in a typeface large enough to be clearly legible.

(3) Nothing in Section 3.5 shall be construed to limit the right of the physician or of personnel associated with him to express to the woman their own views concerning the validity or importance of the materials prescribed by Section 3.5. The materials required under Section 3.5 shall be available at no cost from the Department upon request and in appropriate number to any person, facility or hospital.

5. Kentucky

"The Kentucky Abortion Act of 1982," March 17, 1982, Ky. Acts 311.4.

Informed Consent. (A) No abortion shall be performed except with the voluntary and informed consent of the woman upon whom the abortion is to be performed.

(1) Consent to an abortion is voluntary and informed if and only if:

(a) The woman is provided, at some time before the abortion, with a true copy of her pregnancy test result, if such test has been employed, by the physician who is to perform the abortion or his agent and the woman is provided, at least two hours before the abortion, with the following information by the physician who is to perform the abortion or his agent:

(i) The name of the physician who will perform the abortion,

(ii) The particular medical risks associated with the particular abortion procedure to be employed in the medical judgment of the physician based on the particular facts of the case before him,

(iii) The probable gestational age of the fetus at the time the abortion is to be performed,

(iv) The printed information prescribed in Section 5(1) of this Act, and

(v) The fact that the information prescribed by Section 5(2) of this Act is available to her if she should ask to view it, and

(b) Prior to submitting to the abortion, but subsequent to receiving the information prescribed by paragraph (A) (1) (a) of Section 4 the woman certifies in writing that she has received that information from the physician at least two hours before the abortion is to be performed, that she understands it, that she consents to the abortion, and that her consent is voluntary and not the result of coercion.

(B) Exceptions.

(1) Waiver of waiting period. The requirement of Section 4 (A) (1) (a) of Section 3.2 that at least two hours elapse between the provision of the information prescribed and the performance of the abortion and the requirement of Section (A) (1) (b) shall not apply when, in the medical judgment of the attending physician based on the particular facts of the case before him, there exists a medical emergency which warrants nullification of the two hour waiting peirod. In such

a case, the physician shall describe the basis of his medical judgment that such an emergency exists on a form prescribed by the Department as required by Section 8 of this Act.

(2) Limitation of Informed Consent Requirements. Section 4(A) shall not apply when, in the medical judgment of the attending physician based on the particular facts of the case before him, there exists a medical emergency which warrants nullification of the requirements that the woman be provided with the information prescribed by Section 4 (A) (1) (a) and that the woman certify her consent as prescribed by Section 4 (1) (b). In such a case, the physician shall describe the basis of his medical judgment that such an emergency exists on a form prescribed by the Department as required by Section 8 of this Act and, if the woman survives the abortion, the physician shall subsequently inform her of the medical indications for his judgment that a medical emergency existed and of the particular medical risks associated with the particular abortion procedure employed the symptoms of which might become manifest in the future.

"The Kentucky Abortion Act of 1982," March 17, 1982, Ky. Acts 311.5.

Printed Information. The Department for Human Resources shall, within 60 days after Section 4 becomes law, cause to be published printed materials that may be easily comprehended in all languages used by significant portions of the population of this Commonwealth.

(1) Materials designed to inform concerned persons of public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while the child is dependent, including reputable adoption agencies. Such materials shall include a comprehensive list of the agencies available, the services

they offer, and a description of the manner in which they might be contacted. Such materials shall include the following paragraph:

"There are many public and private agencies willing and able to help you to carry your child to term, and assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The Commonwealth of Kentucky strongly urges you to contact them before making a final decision about abortion," and

(2) Materials designed to inform concerned persons of the probable anatomical and physiological characteristics of the fetus at the various gestational ages at which abortion might be performed, including any relevant information on the possibility of fetal survival. The materials shall be scientifically objective and shall not be prejudicial.

(2) Nothing in Secion 5 shall be construed to limit the right of the physician or of personnel associated with him to express to the woman their own views concerning the validity or importance of the materials prescribed by Section 5. The materials required under Section 5 shall be available at no cost from the Department for Human Resources upon request and in appropriate number to any person, facility or hospital. Distribution of the printed materials of Section 5 pursuant to Section 4 of this Act shall not be required until or unless they are made available.

6. Louisiana

La. Rev. Stat. Ann. §40:1299.35.6 (West Supp. 1981).

A. No abortion shall be performed or induced without the informed, written consent of the pregnant woman, given freely and without coercion.

B. In order to insure that the pregnant woman is able to give her informed consent, the attending physi-

cian, prior to performing or inducing the abortion, shall orally inform the pregnant woman of the facts set forth in this Subsection and shall require the signature of the woman on a consent form wherein she acknowledges that she has been informed:

(1) That, according to the best judgment of the attending physician, she is pregnant.

(2) Of the number of weeks which have elapsed from the probable time of the conception of the unborn child, based on the information provided by her as to the time of her last menstural period or based upon a history, physical examination, and appropriate laboratory tests.

(3) Of the anatomical and physiological development of the particular unborn child at the time the abortion is to be performed or induced, according to the best medical judgment of the attending physician.

(4) That the unborn child is viable, or not viable, according to the best medical judgment of the attending physician.

(5) Of the type of method or technique which will be utilized in the abortion, the means of effectuating the method or technique, and the medical risks and consequences of the method or technique to be utilized.

(6) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and services.

(7) That locations of public mental health agencies shall be available to the patient if and when postpartum psychological damage requires professional attention.

C. At the same time the attending physician provides the information required by Subsection B of this Section, he shall, at least orally, inform the pregnant woman of the particular risks associated with her own pregnancy and the abortion technique to be employed, including providing her, at a minimum, with a general description of the medical instructions to be followed after the abortion in order to insure her safe recovery, and, in addition, shall provide her with such other information as in his own medical judgment is relevant to her decision as to whether to have an abortion or to carry her pregnancy to term.

D. The attending physician performing or inducing the abortion shall provide the pregnant woman with a copy of the consent form signed by her in accordance with Subsection B of this Section.

7. Maine

Me. Rev. Stat. Ann. tit. 22, §1599 (Supp. 1981).

1. *Consent by the woman.* No physician shall perform an abortion unless, prior to the performance, the attending physician certifies in writing that the woman gave her informed written consent freely and without coercion. He shall also certify that, not less than 48 hours prior to her consent, he informed the woman of the information contained in subsection 2. He shall further certify in writing the pregnant woman's age based upon proof of age offered by her.

2. *Informed consent.* In order to insure that the consent for an abortion is truly informed consent, the attending physician shall inform the woman in a manner which, in his professional judgment, is not misleading and which will be understood by the patient, of at least the following:

A. According to his best judgment she is pregnant;

B. The number of weeks elapsed from the probable time of the conception;

C. The particular risks associated with her own pregnancy and the abortion technique to be performed; and

D. Alternatives to abortion such as childbirth and adoption and information concerning public and private agencies that will provide the woman with economic and other assistance to carry the fetus to term, including, if the woman so requests, a list of these agencies and the services available from each.

3. *Exception.* The 48-hour period required in subsection 1 shall not be required if an abortion is immediately necessary to preserve the life or health of the pregnant women.

8. Maryland

Md. Ann. Code art. 43, §138 (1980).

Information to be provided before abortion.

(a) Before a physician performs an abortion the woman undergoing the procedure shall be advised of:

(1) The extent to which financial and other material assistance to carry the pregnancy to a normal delivery is available;

(2) The extent to which financial and other material assistance to raise and support her child is available; and

(3) The extent to which assistance from licensed and regulated adoption agencies is available if she chooses not to keep the baby.

(b) The Department of Human Resources in cooperation with the Department of Health and Mental Hygiene shall annually prepare, periodically update, and publish a list of federal, State, and private sources of the types and extent of assistance referred to in subsection (a), and shall distribute this published information to all hospitals, clinics, physicians' offices, and other facilities where abortions are performed.

(c) The signing of a document by a person seeking an abortion indicating that she has been counselled concerning the published information referred to in subsection (b) shall be evidence that the requisite information was given to the person. The signed document shall become part of the medical record.

(d) This section does not apply when it is certified by the attending physician that abortion is necessary to save the life of the pregnant woman.

(e) Any person who willfully violates the provisions of subsection (a), is guilty of a misdemeanor and upon conviction is subject to a fine of not more than $500.

9. Massachusetts

Mass. Ann. Laws ch. 112, §12S (Michie/Law, Co-op. Supp. 1982).

Informed Consent of Mother for Abortion; Consent of Parents or Guardian or Court Order for Abortion if Mother is Less Than Eighteen

No physician may perform an abortion upon a pregnant woman without first obtaining her written informed consent. The commissioner of public health shall prescribe a form for physicians to use in obtaining such consent. This form shall be written in a manner designed to permit a person unfamiliar with medical terminology to understand its purpose and content, and shall include the following information: a description of the stage of development of the unborn child; the type of procedure which the physician intends to use to perform the abortion; and the possible complications associated with the use of the procedure and with the performance of the abortion itself; the availability of alternatives to abortion; and a statement that, under the law of the commonwealth, a person's refusal to undergo an abortion does not constitute grounds for the denial of public assistance. A pregnant woman seeking an abortion shall sign the consent form described above at least twenty-four hours in advance of the time for which the abortion is scheduled, except in an emergency requiring immediate action. She shall then return it to the physician performing the abortion who shall maintain it in his files and destroy it seven years after the date upon which the abortion is performed.

The said consent form and any other forms, transcript of evidence, or written findings and conclusions of a court, shall be confidential and may not be released

to any person except by the pregnant woman's written informed consent or by a proper judicial order, other than to the pregnant woman herself, to whom such documents relate, the operating physician, or any person whose consent is required pursuant to this section, or under the law. If a pregnant woman is less than eighteen years of age and has not married, a physician shall not perform an abortion upon her unless he first obtains both the consent of the pregnant woman and that of her parents, except as hereinafter provided. In deciding whether to grant such consent, a pregnant woman's parents shall consider only their child's best interests. If one of the pregnant woman's parents has died or is unavailable to the physician within a reasonable time and in a reasonable manner, consent of the remaining parent shall be sufficient. If both parents have died or are otherwise unavailable to the physician within a reasonable time and in a reasonable manner, consent of the pregnant woman's guardian or guardians shall be sufficient. If the pregnant woman's parents are divorced, consent of the parent having custody shall be sufficient. If a pregnant woman less than eighteen years of age has not married and if one or both of her parents or guardians refuse to consent to the performance of an abortion, or if she elects not to seek the consent of one or both of her parents or guardians, a judge of the superior court department of the trial court shall, upon petition, or motion, and after an appropriate hearing, authorize a physician to perform the abortion if said judge determines that the pregnant woman is mature and capable of giving informed consent to the proposed abortion or, if said judge determines that she is not mature, that the performance of an abortion upon her would be in her best interests.

A pregnant woman less than eighteen years of age may participate in proceedings in the superior court department of the trial court on her own behalf, and the court may appoint a guardian ad litem for her. The court shall, however, advise her that she has a right to court appointed counsel, and shall, upon her request, provide her with such counsel. Proceedings in the superior court department of the trial court under this section shall be confidential and shall be given such precedence over other pending matters that the court may reach a decision promptly and without delay so as to serve the best interests of the pregnant woman. A judge of the superior court department of the trial court who conducts proceedings under this section shall make in writing specific factual findings and legal conclusions supporting his decision and shall order a record of the evidence to be maintained including his own findings and conclusions.

Nothing in this section is intended to abolish or limit any common law rights of persons other than those whose rights it governs for the purpose of any civil action or any action for injunctive relief under section twelve.

10. Minnesota

Minn. Stat. Ann. §145.412(1)(4) (West. Supp. 1981).

It shall be unlawful to wilfully perform an abortion unless the abortion is performed . . . with the consent of the woman submitting to the abortion after a full explanation of the procedure and effect of the abortion.

11. Missouri

Mo. Ann. Stat. §188.039 (Vernon Supp. 1982).

Consent, form, content—coercion prohibited—woman to be informed of certain facts, when

1. No physician shall perform an abortion unless, prior to such abortion, the physician certifies in writing that the woman gave her informed consent, freely and without coercion, after the attending physician had informed her of the information contained in subsection 2 of this section not less than forty-eight hours prior to her consent to the abortion, and shall further certify in writing the pregnant woman's age, based upon proof of age offered by her.

2. In order to insure that the consent for an abortion is truly informed consent, no abortion shall be performed or induced upon a pregnant woman unless she has signed a consent form that shall be supplied by the state division of health, acknowledging that she and, if she is a minor, her parent or legal guardian or person standing in loco parentis have been informed by the attending physician of the following facts:

(1) That according to the best medical judgment of her attending physician she is pregnant;

(2) The number of weeks elapsed from the probable time of conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period and after a history and physical examination and appropriate laboratory tests;

(3) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(4) The immediate and long-term physical dangers of abortion and psychological trauma resulting from abortion and any increased incidence of premature births, tubal pregnancies and stillbirths following abortion;

(5) The particular risks associated with the abortion technique to be used;

(6) Alternatives to abortion shall be given by the attending physician, including a list of public and private agencies and services that will assist her during her pregnancy and after the birth of her child.

3. The physician may inform the woman of any other material facts or opinions, or provide any explanation of the above information which, in the exercise of his best medical judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

12. Montana

Mont. Code Ann. §50-20-104(3) (1981).

Definitions. As used in this chapter, the following definitions apply:

. . . (3) "Informed consent" means voluntary consent to an abortion by the woman upon whom the abortion is to be performed only after full disclosure to her by the physician who is to perform the abortion of such of the following information as is reasonably chargeable to the knowledge of the physician in his professional capacity:

(a) the stage of development of the fetus, the method of abortion to be utilized, and the effects of such abortion method upon the fetus;

(b) the physical and psychological effects of abortion; and

(c) available alternatives to abortion, including childbirth and adoption.

Mont. Code Ann. §50-20-106 (1981).

Consent to abortion. (1) No abortion may be performed upon any woman in the absence of informed consent.

(2) Informed consent may be evidenced by a written statement in a form prescribed by the department and signed by the physician and the woman upon whom the abortion is to be performed in which the physician certifies that he has made the full disclosure provided in 50-20-104(3) and in which the woman upon whom the abortion is to be performed acknowledges that the above disclosures have been made to her and that she voluntarily consents to the abortion.

(3) The above informed consent or consent is not required if a licensed physician certifies the abortion is necessary to preserve the life of the mother.

(4) No executive officer, administrative agency, or public employee of the state or of any local governmental body has power to issue any order requiring an abortion or shall coerce any woman to have an abortion, nor shall any person coerce any woman to have an abortion.

(5) Violation of subsections (1) and (4) of this section is a misdemeanor.

13. Nebraska

Neb. Rev. Stat. §28-326 (1981).

Definitions:

. . . (8) Informed consent shall mean a written statement, voluntarily entered into by the person upon whom an abortion is to be performed, whereby she specifically consents to such abortion. Such consent shall be deemed to be an informed consent only if it affirmatively appears in the written statement that the person upon whom the abortion is to be performed has been advised (a) of the reasonably possible medical and mental consequences resulting from an abortion, pregnancy, and childbirth, (b) of possible alternatives to abortion, including childbirth and adoption and including that there are agencies and services available to assist her to carry her pregnancy to a natural term, and (c) of the abortion procedures to be used. Such statement shall bear the signature of the person upon whom the abortion is to be performed and be signed by the attending physician.

Neb. Rev. Stat. §28-327 (1981).

Abortion; informed consent required; waiting period; exception. No abortion shall be performed on any woman in the absence of an informed consent, except that an abortion may be performed if, in the sound medical judgment of the physician, an emergency presents imminent peril that substantially endangers the life of the woman and the woman is unable to give informed consent.

No abortion shall be performed on any woman without the passing of at least forty-eight hours between

the expression of informed consent and the actual performance of the abortion unless, in the sound medical judgment of the physician, an emergency situation exists.

14. Nevada

Nev. Rev. Stat. §442.253 (1981).

Requirements for informed consent.

1. The attending physician shall accurately and in a manner which is reasonably likely to be understood by the pregnant woman:

(a) Explain that in his professional judgment, she is pregnant and a copy of her pregnancy test is available to her.

(b) Inform her of the number of weeks which have elapsed from the probable time of conception.

(c) Explain any known immediate and long-term physical or psychological dangers resulting from abortion including an increase in the incidence of premature births, tubal pregnancies and stillbirths.

(d) Explain the general nature and the extent of the particular risks associated with her pregnancy.

(e) Describe the medical procedure to be used.

(f) Present any alternatives to abortion including a list of public and private agencies that provide pregnant women with economic and other assistance and the services provided by each agency

(g) Explain that if the child is aborted is alive, the physician has a legal obligation to take all reasonable steps to preserve the life and health of the child.

(h) Present any other material facts which, in his professional judgment, are necessary to allow the woman to give her informed consent.

2. If the woman does not understand English, the form indicating consent must be written in a language understood by her, or the attending physician shall certify on the form that the information required to be given has been presented in such a manner as to be understandable by her. If an interpreter is used, the interpreter must be named and reference to this use must be made on the form for consent.

15. North Dakota

N.D. Cent. Code §14-02.1-02(5).

Definitions.

. . . 5. "Informed consent" means voluntary consent to abortion by the woman upon whom the abortion is to be performed only after full disclosure to her by the physician who is to perform the abortion of as much of the following information as is reasonably chargeable to the knowledge of the physician in his professional capacity:

a. According to the best judgment of her attending physician, she is pregnant.

b. The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or based upon a history and physical examination and appropriate laboratory tests.

c. The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.

d. The immediate and long-term physical dangers of abortion, psychological trauma resulting from abortion, sterility and increases in the incidence of premature births, tubal pregnancies and still-births in subsequent pregnancies, as compared to the dangers in carrying the pregnancy to term.

e. The particular risks associated with her own pregnancy and the abortion technique to be performed.

f. Alternatives to abortion such as childbirth and adoption and information concerning public and private agencies that will provide the woman with economic and other assistance and encouragement to carry her child to term including, if the woman so requests, a list of the agencies and the services available from each.

g. In cases where the fetus may reasonably be expected to have reached viability and thus be capable of surviving outside of her womb, the attending physician shall inform the woman of the extent to which he is legally obligated to preserve the life and health of her viable unborn child during and after the abortion.

In addition, the physician may inform the woman of any other material facts or opinions or provide any explanation of the above information which, in the exercise of his best medical judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

Informed consent shall be evidenced by a written statement, in the form prescribed by the state department of health and approved by the attorney general,

signed by the physician and the woman upon whom the abortion is to be performed, in which statement the physician certifies that he has made the full disclosure provided above; and in which statement the woman upon whom the abortion is to be performed acknowledges that the above disclosures have been made to her and that she voluntarily consents to the abortion.

Informed consent shall not be required in the event of a medical emergency when the woman in incapable of giving her consent if a licensed physician certifies the abortion is necessary to prevent her death.

16. Ohio

Ohio Rev. Code Ann. §2919.12(A) (Page 1982).

No person shall perform or induce an abortion without the informed consent of the pregnant woman.

17. Oklahoma

Okla. Stat. Ann. tit. 63, §1-736 (West Supp. 1981-1982). *Hospitals — Advertising of Counseling to Pregnant Women.*

No hospital in which abortions are performed or induced shall advertise or hold itself out as providing counseling to pregnant women, unless:

1. The counseling is done by a licensed physician, a licensed registered nurse or by a person holding at least a bachelor's degree from an accredited college or university in psychology or some similarly appropriate field;

2. The counseling includes factual information, including explicit discussion of the development of the unborn child; and

3. The counseling includes a thorough discussion of the alternatives to abortion and the availability of agencies and services to assist her if she chooses not to have an abortion.

18. Pennsylvania

Act of June 15, 1982 Pa. Laws

A. *Informed Consent*—No abortion shall be performed or induced except with the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(1) The woman is provided, at least 24 hours before the abortion, with the following information by the physician who is to perform the abortion or by the referring physician but not by the agent or representative of either;

(i) The name of the physician who will perform the abortion.

(ii) The fact that there may be detrimental physiological and psychological effects which are not foreseeable.

(iii) The particular medical risks associated with the particular abortion procedure to be employed including, where medically accurate, the risks of infection, hemorrhage, danger to subsequent pregnancies and infertility.

(iv) The probable gestational age of the unborn child at the time the abortion is to be performed.

(v) The medical risks associated with carrying the child to term.

(2) The woman is informed, by the physician or agent, at least 24 hours before the abortion:

(i) of the fact that medical assistance benefits may be available for prenatal care, childbirth and neonatal care;

(ii) of the fact that the father is liable to assist in the support of her child, even in instances where the father has offered to pay for the abortion;

(iii) and, that she has the right to review the printed materials described in §3208 (related to printed information). The physician or agent shall orally inform the woman that the material describes the unborn child and lists agencies which offer alternatives to abortion. If the woman chooses to view the material, copies of them will be furnished to her. If the woman is unable to read the material furnished to her, the material shall be read to her. If the woman seeks answers to questions concerning any of the information and materials, answers shall be provided in her own language.

(3) The woman certifies in writing, prior to the abortion, that the information described in (1) and (2) has been furnished to her, and that she has been informed of her opportunity to review the information referred to in paragraph (2).

(4) Prior to the performance of an abortion, the physician who is to perform or induce the abortion or his agent receives the copy of the written certification described by paragraph (3).

B. *Emergency*—Where a medical emergency compels the performance of an abortion, the physician shall inform the woman, prior to the abortion if possible, that an abortion is necessary to avert her death.

C. *Penalty*—Any physician who violates the provisions of this section is guilty of "unprofessional conduct" and his license for the practice of medicine and surgery shall be subject to suspension or revocation in accordance with procedures provided under the Act of July 20, 1974, (P.L. 551, No. 190), known as the "Medical Practice Act of 1974." Any other person obligated under this chapter to give information relating to informed consent of a woman before an abortion is performed, and who fails to give such information, shall for the first offense be guilty of a summary offense and, for each subsequent offense, be guilty of a misdemeanor of the second degree.

D. *Limit on Civil Liability*—Any physician who complies with provisions of this section may not be held civilly liable to his patient for failure to obtain informed consent to the abortion within the meaning of that term as defined by the Act of October 15, 1975.

20. Rhode Island

R.I. Gen. Laws §23-4.7-2 (1981).

Required disclosure—In order to insure that the consent of the pregnant woman is truly informed consent, an abortion shall be performed only after the woman has signed a consent form acknowledging that she has been informed by the physician who is to perform the abortion as follows:

(1) That she is pregnant and a copy of her pregnancy test is available to her.

(2) That the nature of an abortion has been fully explained, including the probable gestational age of the fetus at the time the abortion is to be performed.

(3) That the medical or surgical procedure to be used has been explained, to include all medical risks, both physical and psychological, associated with the particular abortion procedure to be employed, consistent with good medical practice.

(4) That the printed information prescribed in §23-4.7-4 is available, if in fact it has been made available by the department of health.

(5) That the woman be informed of all medical risks, both physical and psychological, to herself and the fetus, associated with the alternative of carrying the fetus to term, consistent with good medical practice.

In addition, the physician may inform the woman of any other material facts or opinions or provide any explanation of the above information, which in the exercise of his best medical judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

In cases where the woman does not understand English, either the consent form shall be written in a language understood by her, or the physician informing her shall certify on the consent form that in his or her opinion, the information required in this section has been given in such a manner as to be understandable by her; if an interpreter is used, the interpreter shall be named and reference to such use shall be made on the consent form.

R.I. Gen. Laws §23-4.7-4 (1981).

Printed information—The department of health shall, within sixty (60) days after this section becomes law, cause to be published, printed materials that may be easily comprehended in all languages used by significant portions of the population of this state:

(1) Materials designed to inform concerned persons of public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while the child is dependent, including a comprehensive list of the agencies available and a description of the manner in which they might be contacted; and,

(2) Materials designed to inform concerned persons of the probable anatomical and physiological characteristics of the fetus at the various gestational ages at which abortion might be performed, including any relevant information on the possibility of fetal survival.

21. South Dakota

S.D. Codified Laws Ann. §34-23A-10 (1977).

Information and counseling required of physicians and facilities—Alternative solutions. All physicians performing abortions and facilities wherein abortions are performed shall make available to all women seeking abortions from them, upon request, information concerning professional social service and counseling service agencies in the state which provide a full spectrum of alternative solutions for problem pregnancies.

S.D. Codified Laws Ann. §34-23-A-10.1 (Supp. 1981).

Statement of informed consent—Physician's duties—Signature—Copies. At least twenty-four hours before an abortion is scheduled on a woman, unless, in the

best medical judgment of the attending physician based upon the particular facts of the case before him, an emergency situation presents imminent peril substantially endangering the life of the woman, the physician shall request that she sign the following statement which shall be provided by the department of social services:

> "This is to advise you that you have many alternatives to abortion. One such alternative is adoption. Many qualified persons are unable to adopt because there are not enough children available. If you decide to carry your baby to term and place it for adoption, financial assistance may be available to you. Financial assistance may also be available to you if you decide to keep your child. You may learn more about your choices, and you may apply for benefits at ———— (place and telephone number of nearest social service offices).
>
> ————————————
>
> (signature of the pregnant woman)"

If the woman refuses to sign this statement, the physician or his designee shall read the statement to her, note that fact on the statement, and then sign the statement himself. A copy of the statement shall be given to the woman. . . .

22. Tennessee

Tenn. Code Ann. §39-302 (Supp. 1981).

Consent of pregnant woman required prior to abortion —Information provided by doctor—Waiting period—Penalty for violation—Requirements inapplicable in certain cases.-(a) an abortion otherwise permitted by law shall be performed or induced only with the

informed written consent of the pregnant woman, given freely and without coercion. Such consent shall be treated as confidential.

(b) In order to insure that a consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she has been orally informed by her attending physician of the following facts and has signed a consent form acknowledging that she has been informed as follows:

(1) That according to the best judgment of her attending physician she is pregnant.

(2) The number of weeks elapsed from the probable time of the conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period or after a history, physical examination, and appropriate laboratory tests.

(3) That if more than twenty-four (24) weeks have elapsed from the time of conception, her child may be viable, that is, capable of surviving outside of the womb, and that if such child is prematurely born alive in the course of an abortion her attending physician has a legal obligation to take steps to preserve the life and health of the child.

(4) That abortion in a considerable number of cases constitutes a major surgical procedure.

(5) That numerous public and private agencies and services are available to assist her during her pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(6) Numerous benefits and risks are attendant either to continued pregnancy and childbirth or to abortion depending upon the circumstances that the patient might find herself in. The physician shall explain these benefits and risks to the best of his ability and knowledge of the circumstances involved.

(c) At the same time the attending physician provides the information required by subsection (b) of this section, he shall inform the pregnant woman of the particular risks associated with her pregnancy and childbirth and the abortion or child delivery technique to be employed, including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion or childbirth in order to insure her safe recovery.

(d) There shall be a two (2) day waiting period after the physician provides the required information, excluding the day on which such information was given and on the third day following the day such information was given, the patient may return to the physician and sign a consent form.

Any physician who performs an abortion or attempts to perform an abortion in violation of the provisions of this subsection shall be punished by imprisonment in the penitentiary for not less than one (1) nor more than three (3) years.

Provided, however, that this subsection (d) shall not apply when the attending physician, utilizing his experience, judgment, or professional competence, determines that a two (2) day waiting period or any waiting period would endanger the life of the pregnant woman.

This provision shall not relieve the attending physician of his duty to the pregnant woman to inform her

of the facts under subsection (b) of this section. Such determination made by the attending physician shall be in writing and shall state his medical reasons upon which he bases his opinion that the waiting period would endanger the life of the pregnant woman.

(e) The attending physician performing or inducing the abortion shall provide the pregnant woman with a duplicate copy of the consent form signed by her.

(f) The attending physician or agency performing an abortion upon a minor of less than eighteen (18) years of age shall inform the parents or legal guardians of such minor, or if the whereabouts of the parents cannot be determined and there is no other legal guardian than the agency or other individual to whom the child's custody has been transferred, two (2) days prior to the operation that an abortion is to be performed upon such minor. Provided, however, the provisions of this section shall in no way be construed to mean, provide for, or authorize parental objection to, in any way, prevent or alter the decision of the minor to proceed with the abortion. Notice shall not be required if:

(1) The minor is emancipated by marriage; or

(2) The attending physician determines that, in his best medical judgment, the abortion is necessary to preserve the life or health of the mother and must be performed prior to the expiration of the two (2) day notice period.

(g) The words "the physician" and "the attending physician" as used in this section shall mean any licensed physician on the service treating the pregnant woman.

(h) The provisions of this section shall not apply in those situations where an abortion is certified by a licensed physician as necessary to preserve the life of the pregnant woman.

23. Utah

Utah Code Ann. §76-7-305 (1979).

Consent requirements for abortion. (1) No abortion may be performed unless a voluntary and informed written consent is first obtained by the attending physician from the woman upon whom the abortion is to be performed.

(2) No consent obtained pursuant to the provisions of this section shall be considered voluntary and informed unless the attending physician has informed the woman upon whom the abortion is to be performed:

(a) Of the names and addresses of two licensed adoption agencies in the state of Utah and the services that can be performed by those agencies, and nonagency adoption may be legally arranged; and

(b) Of the details of development of unborn children and abortion procedures, including any forseeable complications, risks, and the nature of the postoperative recuperation period; and

(c) Of any other factors he deems relevant to a voluntary and informed consent.

Utah Code Ann. §76-7-305.5 (Supp. 1981).

Information to be furnished to pregnant woman prior to abortion—Exceptions. (1) In order to insure that the consent to an abortion is truly informed consent, the department of health shall cause to be published

easily comprehended printed materials to be made available at no cost to any person upon request and which shall contain the following:

(a) Descriptions of the services available to assist a woman through pregnancy, at childbirth, and while the child is dependent, including adoption services, a comprehensive list of the names, addresses, and telephone numbers of public and private agencies that provide such services and financial aid available;

(b) Descriptions of the physical characteristics of a normal unborn child, described at two-week intervals, beginning with the fourth week and ending with the twenty-fourth week of development, accompanied by scientifically verified photographs of an unborn child during such stages of development. The descriptions shall include information about physiological and anatomical characteristics, brain and heart function, and the presence of external members and internal organs during the applicable stages of development; and

(c) Descriptions of abortion procedures used in current medical practice at the various stages of growth of the unborn child including, (sic) the surgical procedure to be used and any reasonably foreseeable complications and risks to the mother, including those related to subsequent childbearing.

(2) No abortion shall be performed unless, prior to the abortion, the attending physician certifies in writing that the materials referred to in subsection (1) of this section have been provided to the woman, if possible, at least 24 hours before performance of the abortion.

(3) This section is inapplicable to an abortion if the department certifies in writing that the materials referred to in subsection (1) are not presently available.

If any provision of this section is invalidated by a court, it shall not affect the validity of the balance of its provisions.

(4) When due to a serious medical emergency, time does not permit compliance with subsection 76-7-305.5(2), the provisions of that subsection shall not apply.

24. Virginia

Va. Code. 18.2-76 (1982).

Informed consent required.—Before performing any abortion or inducing any miscarriage or terminating a pregnancy as provided for in §§ 18.2-72, 18.2-73 or 18.2-74, the physician shall obtain the informed written consent of the pregnant woman; provided, however, if such woman shall be incompetent as adjudicated by any court of competent jurisdiction or if the physician knows or has good reason to believe that such woman is incompetent as adjudicated by a court of competent jurisdiction, then only after permission is given in writing by a parent, guardian, committee, or other person standing in loco parentis to such incompetent, may the physician perform such abortion or otherwise terminate the pregnancy.

The physician shall inform the pregnant woman of the nature of the proposed procedure to be utilized and the risks, if any, in her particular case to her health in terminating or continuing the pregnancy. (Code 1950, § 18.1-62.1; 1970, c. 508; 1972, c. 823; 1975, cc. 14, 15; 1979, c. 250.)

AUG 4 1982

Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

(Names of Individual Amici appear within)

SUSAN FRELICH APPLETON
Washington University School of Law
St. Louis, MO. 63130
(314) 889-6449

PAUL BREST
Stanford Law School
Stanford, CA. 94305
(415) 497-3573

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,

Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,

Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,

Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,

Plaintiffs-Respondents.

INDIVIDUAL AMICI

Richard L. Abel
Professor of Law
University of California at Los Angeles School of Law

Francis A. Allen
Sutherland Professor of Law
University of Michigan School of Law

Anthony G. Amsterdam
Professor of Law
New York University School of Law

Claudia Angelos
Clinical Assistant Professor of Law
New York University School of Law

Frank Askin
Professor of Law
Rutgers Law School

Paul Bender
Professor of Law
University of Pennsylvania Law School

Thomas Blumenthal
Clinical Law Teacher
Washington University School of Law

Richard Bonnie
Professor of Law
University of Virginia School of Law

Susan Bryant
Assistant Clinical Professor
Hofstra University School of Law

John M. Burkoff
Professor of Law
University of Pittsburgh School of Law

Janet M. Calvo
Assistant Clinical Professor of Law
New York University School of Law

Oscar G. Chase
Professor of Law
New York University School of Law

Patricia Dore
Associate Professor of Law
Florida State University
College of Law

John N. Drobak
Associate Professor of Law
Washington University School of Law

Thomas I. Emerson
Lines Professor of Law Emeritus
Yale Law School

Martha A. Field
Professor of Law
Harvard University Law School

Eleanor M. Fox
Professor of Law
New York University School of Law

Ann E. Freedman
Associate Professor of Law
Rutgers Law School

Lawrence A. Frolik
Professor of Law
University of Pittsburgh School of Law

Stephen Gillers
Professor of Law
New York University School of Law

Gary Goodpaster
Professor of Law
University of California at
Davis School of Law

Robert J. Goodwin
Clinical Law Teacher
Washington University School of Law

Jacob Hyman
Professor of Law Emeritus
Buffalo School of Law, S.U.N.Y.

Jonathan M. Hyman
Associate Professor of Law
Rutgers Law School

Louis A. Jacobs
Associate Professor of Law
Ohio State University College of Law

William C. Jones
Professor of Law
Washington University School of Law

Jane Kammerman
Clinical Professor
University of Minnesota Law School

James C. Kirby, Jr.
Professor of Law
University of Tennessee College of Law

John R. Kramer
Associate Dean and Professor
Georgetown University Law Center

Richard B. Kuhns
Professor of Law
University of Iowa College of Law

David P. Leonard
Assistant Professor of Law
Indiana University School of Law

Howard Lesnick
Professor of Law
C.U.N.Y. Law School

John Leubsdorf
Professor of Law
Boston University School of Law

Ronald M. Levin
Associate Professor of Law
Washington University School of Law

Daniel R. Mandelker
Stamper Professor of Law
Washington University School of Law

Pamela E. Mann
Staff Attorney, Constitutional
Litigation Clinic
Rutgers Law School

Robert B. McKay
Professor of Law
New York University School of Law

Alan Meisel
Professor of Law
University of Pittsburgh School of Law

Carrie Menkel-Meadow
Acting Professor of Law
University of California at Los
Angeles School of Law

Roy M. Mersky
Professor of Law
University of Texas Law School

Arthur S. Miller
Professor of Law Emeritus
George Washington University National
Law Center

Elliott Milstein
Professor of Law
American University,
Washington College of Law

Chester L. Mirsky
Professor of Law
New York University School of Law

Alice Morey
Assistant Clinical Professor
Hofstra University School of Law

Burt Neuborne
Professor of Law
New York University School of Law

Wade J. Newhouse
Professor of Law
S.U.N.Y. at Buffalo School of Law

Marcia O'Kelly
Associate Professor of Law
University of North Dakota
School of Law

John de J. Pemberton, Jr.
Professor of Law
University of San Francisco
School of Law

Michael J. Perry
Professor of Law
Ohio State University College of Law

Joan Pransky
Staff Attorney, Urban Legal Clinic
Rutgers Law School

Philip J. Prygoski
Associate Professor of Law
Thomas M. Cooley Law School

Louis Raveson
Assistant Professor of Law
Rutgers Law School

Steven Reiss
Assistant Professor of Law
New York University School of Law

Judith Resnik
Associate Professor of Law
University of Southern California
Law Center

David A.J. Richards
Professor of Law
New York University School of Law

Rhonda R. Rivera
Professor of Law
Ohio State University College of Law

Rand E. Rosenblatt
Professor of Law
Rutgers Law School

Patricia E. Rousseau
Assistant Professor of Law
Rutgers Law School

David Rudovsky
Instructor of Law
University of Pennsylvania Law School

Laura Sager
Associate Clinical Professor of Law
New York University School of Law

Elizabeth M. Schneider
Staff Attorney, Constitutional
Litigation Clinic
Rutgers Law School

Robert A. Sedler
Professor of Law
Wayne State University Law School

Herbert Semmel
Professor of Law
Antioch School of Law

Annamay T. Sheppard
Professor of Law
Rutgers Law School

Susan A. Short
Clinical Professor
University of Minnesota Law School

Eileen Silverstein
Professor of Law
University of Connecticut
School of Law

Robert H. Smith
Assistant Professor of Law
Boston College Law School

Edward V. Sparer
Professor of Law and Social Welfare
University of Pennsylvania Law School

Roy G. Spece, Jr.
Professor of Law
University of Arizona College of Law

Edward Steinman
Professor of Law
University of Santa Clara
School of Law

Dale Swihart
Professor of Law
Washington University School of Law

Nadine Taub
Professor of Law
Rutgers Law School

Karen Tokarz
Assistant Professor of Law
Washington University School of Law

Mark Tushnet
Professor of Law
Georgetown University Law Center

William W. Van Alstyne
Professor of Law
Duke University School of Law

Kathleen Waits
Assistant Professor
University of Florida, Spessard
L. Holland Law Center

Michael S. Wald
Professor of Law
Stanford Law School

Joan Wexler
Associate Professor of Law
New York University School of Law

Welsh S. White
Professor of Law
University of Pittsburgh School of Law

Robert Whitman
Professor of Law
University of Connecticut Law School

Wendy W. Williams
Assistant Professor of Law
Georgetown University Law Center

Steven J. Wisotsky
Professor of Law
Nova University Center for the
Study of Law

Diane L. Zimmerman
Associate Professor of Law
New York University School of Law

INDEX

Page

Motion for Leave to File Brief Amici Curiae xxi

Brief Amici Curiae 1

Interest of the Amici 1

Summary of Argument 1

Argument:

I. The fundamental constitutional right of privacy, as elaborated by this Court in Roe v. Wade, protects a woman's abortion decision and her access to the means to effectuate that decision from the direct governmental interference imposed by the regulations now before this Court. . . . 5

II. This Court must scrutinize the abortion regulations now before it against the single standard, strict judicial scrutiny, consistently applied to all regulations directly imposing any burden on the adult woman's privacy right;

Page

II. (continued)
a more relaxed test allowing ad hoc evaluations of the degree of the burden inflicted by abortion regulations would undermine a fundamental constitutional right, conflict with this Court's precedents, and create a judicially unmanageable standard for all fundamental-rights cases. 20

A. Under Roe v. Wade, the abortion regulations now before this Court must be narrowly drawn to advance one of two possible compelling state interests: maternal health (compelling only after approximately the end of the first trimester) and potential life (compelling only after fetal viability). 20

B. This Court's precedents dictate a two-step inquiry to ascertain whether the abor-

Page

B. (continued)
tion regulations at bar are unconstitutional: do the regulations impose any burden at all on the abortion decision and its effectuation and, because these regulations directly impose such burdens, do they fail to satisfy the "compelling state interest" test? . 27

C. Only the "compelling state interest" test --applied here and in all fundamental-rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates . . . 41

III. Because of the unique status of children under the law, this Court has used a special standard

Page

III. (continued)
of review for regulations of abortions for minors, requiring states to allow mature minors to make their own abortion decisions and to free from parental involvement all those minors whose best interests so demand. 55

Conclusion 64

TABLE OF AUTHORITIES

Cases — Page

Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172) 14, 41, 42, 43, 48, 49, 59, 62, 64

Bellotti v. Baird, 443 U.S. 622 (1979) . . 46, 55, 56, 58, 60, 61, 63

Carey v. Population Services International, 431 U.S. 678 (1977) . . 9, 10, 21, 27, 57

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Connecticut v. Menillo, 423 U.S. 9 (1975) . . . 7, 23

Page

Doe v. Bolton,
410 U.S. 179 (1973) . . . 6, 10, 11, 16, 25, 28

Ginsberg v. New York,
390 U.S. 629 (1968) . . 58

Harris v. McRae,
448 U.S. 297 (1980) . . 12, 13, 17, 30, 32, 33, 35, 42

H.L. v. Matheson,
450 U.S. 398 (1981) . . 61, 62, 64

Illinois State Board of Elections v. Socialist Workers Party,
440 U.S. 173 (1979) . . 52

In re Gault,
387 U.S. 1 (1967) . . . 56

Leigh v. Olsen,
497 F.Supp. 1340 (D.N.D. 1980) 48

Maher v. Roe,
432 U.S. 464 (1977) . . 13, 30, 32, 33, 35

Page

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345 U.S. 528 (1953) . . 56

Michael M. v. Superior
Court, 450 U.S. 464
(1981) 56, 57

Moore v. City of
East Cleveland,
431 U.S. 494 (1977) . . 37

Paul v. Davis,
424 U.S. 693 (1976) . . 7

Planned Parenthood
Association of Kansas
City, Missouri, Inc.
v. Ashcroft,
483 F.Supp. 679
(W.D. Mo. 1980),
aff'd in part,
rev'd in part,
655 F.2d 848 (8th
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Cir. 1981), cert.
granted, 50 U.S.L.W.
3934 (U.S. May 25,
1982) (Nos. 81-1255
& 81-1623) 15, 16, 17,
38, 40, 48

Page

Planned Parenthood League v. Bellotti, 641 F.2d 1006 (1st Cir. 1981) 17

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) . . . 11, 16, 18, 19, 22, 25, 28, 29, 30, 31, 32, 38, 57, 58, 60

Prince v. Massachusetts, 321 U.S. 158 (1944) . . 58

Roe v. Wade, 410 U.S. 113 (1973) . . 1, 5, 6, 7, 8, 9, 10, 12, 13, 18, 20, 21, 22, 23, 24, 26, 27, 28, 32, 33, 34, 35, 36, 37, 38, 40, 46, 50, 52, 65

Schad v. Borough of Mount Ephraim, 452 U.S. 61 (1981) . . 44

Page

Simopoulos v. Commonwealth, 277 S.E.2d 194 (Va. 1981), probable jurisdiction noted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-185) . . . 37

Thomas v. Collins, 323 U.S. 516 (1945) . . . 44

Whalen v. Roe, 429 U.S. 589 (1977) . . . 6, 7, 31, 58

Widmar v. Vincent, 102 S.Ct. 269 (1981) . . 52

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Nos. 81-185, 81-746 and 81-1172,
81-1255 and 81-1623

In the
Supreme Court of the United States
October Term, 1982

Chris Simopoulos, M.D., FACOG,
Defendant-Appellant
v.
Commonwealth of Virginia,
State-Appellee

City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive Health,
Inc., et. al.,
Plaintiffs-Respondents

Akron Center for Reproductive Health,
Inc., et al.,
Plaintiffs-Petitioners
v.
City of Akron, et al.,
Defendants-Respondents

Planned Parenthood Association of
Kansas City, Missouri, Inc., et. al.,
Plaintiffs-Petitioners
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents

John L. Ashcroft, Attorney General of
the State of Missouri, et al.,
Defendants-Petitioners
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents

On Appeal from the Supreme Court of Virginia
and on Certiorari to the United States Court
of Appeals for the Sixth Circuit and the
United States Court of Appeals for the
Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

MOTION OF CERTAIN LAW PROFESSORS FOR LEAVE TO FILE BRIEF AMICI CURIAE

The above listed 85 law professors respectfully move the Court for leave to file the accompanying brief amici curiae, in support of defendant below in Simopoulos v. Virginia (No. 81-185); plaintiffs below on all issues in City of Akron v. Akron Center for Reproductive Health, Inc. (Nos. 81-746 & 81-1172); and plaintiffs below on all issues in Planned Parenthood of Kansas City, Missouri, Inc. v. Ashcroft (Nos. 81-1255 & 81-1623), with the exception of the question of statutory construction regarding minors' consent, on which we take no position.

Amici teach in American law schools. We submit this brief to

share with the Court our support for the principles of constitutional law embodied in this Court's opinion in Roe v. Wade, 410 U.S. 113 (1973), and in the Court's subsequent applications of Roe. We believe that, as the ultimate guardian of the precious and delicate constitutional right of privacy as well as the final source of coherent constitutional doctrine, this Court must recognize the continuing validity of Roe. We, therefore, urge this Court to review with the strict judicial scrutiny used in Roe all enactments at bar regulating abortion procedures for adult women and to consider the regulations of abortions for minors against the special standard

of review articulated by this Court in recognition of the unique status of children under the law.

We have sought the consent of the parties to file a brief amici curiae. Counsel for all parties in all three cases have consented, with the exception of counsel for the Commonwealth of Virginia in Simopoulos v. Virginia (No. 81-185).

Respectfully submitted,

Professor Susan Frelich Appleton
Washington University School of Law
St. Louis, Missouri 63130
(314) 889-6449

Professor Paul Brest
Stanford Law School
Stanford, California 94305
(415) 497-3573

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BRIEF AMICI CURIAE OF CERTAIN LAW PROFESSORS

This brief is submitted by the 85 listed individual amici curiae conditionally upon the granting of the attached motion for leave to file.

INTEREST OF THE AMICI

The interest of the amici is set forth in the attached motion for leave to file.

SUMMARY OF ARGUMENT

The constitutional right of privacy, a fundamental liberty shielded by the due process clause of the Fourteenth Amendment and so recognized by this Court in Roe v. Wade, 410 U.S. 113 (1973), presumptively relegates to the individual the intensely personal choice whether or not to terminate a pregnancy. This Court has explicitly determined on many occasions that this

prima facie right encompasses freedom from direct governmental interference with the means to effectuate the abortion choice and that access to abortion is essential to the constitutionally protected right of decision.

When examining enactments regulating abortions sought by adult women, this Court has consistently used a two-step analysis: It has first decided whether the law directly interferes with or imposes any burden at all on the woman's freedom to choose abortion or to effectuate that choice. If the law does so, this Court has then applied strict judicial scrutiny, requiring the law to be not only justified by a compelling state interest but also narrowly tailored to further that

goal. In the abortion context, this Court has identified just two state interests that will reach the "compelling point" -- preserving potential life after fetal viability and protecting maternal health after approximately the end of the first trimester.

This Court's precedents as well as the precious and delicate nature of the fundamental privacy right dictate that the enactments at bar regulating access to abortions for adult women be tested within the analytical framework described above. The balancing test or the sliding scale used as a standard of review by some lower courts would threaten all fundamental constitutional rights and would continually mire the courts in circular and

standardless evaluations of the "burdensomeness" of every abortion regulation.

Because of the unique status of children under the law, this Court has required regulations of abortions sought by minors to be justified by significant state interests not present in the case of an adult, such as the interest in parental involvement. This Court's precedents have recognized, however, that to withstand constitutional attack these abortion regulations must allow mature minors to make their own decisions and must exempt from parental involvement minors whose best interests so require.

ARGUMENT

I.

The fundamental constitutional right of privacy, as elaborated by this Court in Roe v. Wade, protects a woman's abortion decision and her access to the means to effectuate that decision from the direct governmental interference imposed by the regulations now before this Court.

In Roe v. Wade, 410 U.S. 113 (1973), this Court held unconstitutional a Texas statute criminalizing all but life-saving abortions because the "right of privacy ... is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Id. at 153. In so holding, this Court did not decide that abortion is a desirable response to an unhealthful or unwanted pregnancy; instead, it recognized simply that the "Fourteenth Amendment's concept of personal liberty and restrictions upon state

action" presumptively relegate such intensely personal and sensitive matters of conscience to individual choice, not government control. Id.; see Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

The prima facie constitutional right recognized in Roe belongs to the pregnant woman, Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), although this Court has made plain the indispensable role of her physician's best medical judgment in considering all factors relating to her pregnancy, in assisting her in the decisionmaking process, and in implementing her decision, should she choose abortion. See Roe, 410 U.S. at 153, 163; Doe v. Bolton, 410 U.S.

179, 192, 196-97 (1973); Connecticut v. Menillo, 423 U.S. 9 (1975); Colautti v. Franklin, 439 U.S. 379, 387 (1979). Abortion is, after all, a medical procedure, Roe, 410 U.S. at 166, and constraints on a physician's exercise of his best medical judgment necessarily interfere with "the woman's freedom to make a constitutionally protected decision," Whalen, 429 U.S. at 605 n.33.

The zone of privacy shielded by the Fourteenth Amendment, under Roe, encompasses not only "the interest in independence in making certain kinds of important decisions," Whalen, 429 U.S. at 599-600, but also the complementary and inseparable interest in being permitted to effectuate those decisions. See Paul v. Davis, 424 U.S.

693, 713 (1976) (emphasis added) ("limitations on States' power to substantively regulate conduct" in privacy matters). In other words, the interest that Roe found constitutionally secured is not just a theoretical interest in abstract decisionmaking on the subject of abortion; rather, this Fourteenth Amendment liberty necessarily includes protection from unjustified governmental interference with the means of effectuating a woman's abortion choice. Regarding the first trimester of pregnancy, for example, this Court held in Roe that "[i]f [the abortion] decision is reached, the judgment may be effectuated by an abortion free of interference by the State," 410 U.S. at 163 (emphasis added), and that "the abortion decision and its effectuation

must be left to the medical judgment of the pregnant woman's attending physician," id. at 164 (emphasis added).

This principle was forcefully reaffirmed in Carey v. Population Services International, 431 U.S. 678 (1977), where this Court found its privacy precedents to "establish that the same test must be applied to state regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely." Id. at 688. This Court reasoned that "access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the under-

lying foundation of the [holding] in ... Roe v. Wade." Id. at 688-89. Thus, New York's restrictions on access to contraceptives, including a requirement that only licensed pharmacists distribute contraceptives, were invalid because they unjustifiably burdened the right of individuals to use such items. Id. at 686-90.

This Court's repeated reliance on the reasoning used in Roe to strike down restrictions falling far short of complete prohibitions of abortions clearly demonstrates the centrality of access to the means of effectuating the abortion decision. For example, Roe's reasoning was invoked in its companion case, Doe v. Bolton, to overturn the procedural provisions of Georgia's "modern" abortion legislation, includ-

ing special hospitalization, accreditation, committee-approval, and two-doctor concurrence requirements. These requirements did not bar abortions altogether, and abortions remained available so long as physicians complied (under threat of criminal penalties) with these regulations. Nonetheless, this Court concluded that Georgia had, without sufficient justification, limited a physician's exercise of his best medical judgment--and thus derivatively his patient's right of privacy. 410 U.S. at 192-200. Three years later, Missouri's spousal consent requirement and its ban on saline amniocentesis (a then popular method of second-trimester abortion) fell when subjected to the analysis dictated by Roe and Doe. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

Both requirements, provisions accompanied by criminal sanctions for noncompliance, blocked a woman's access without, however, completely prohibiting abortion.

The constitutional constraints that prevent government from interfering with the abortion choice and its effectuation do not require government actively to assist women to obtain abortions, even women unable to afford to pay for such treatment themselves. Harris v. McRae, 448 U.S. 297 (1980) (federal government); Williams v. Zbaraz, 448 U.S. 358 (1980) (states). Taking care to emphasize the continuing validity of the Roe doctrine, this Court has determined that government inaction--such as the failure to fund abortions for the indigent--simply does not impinge on the protected right to obtain an abortion, free from official

interference. McRae, 448 U.S. at 314, 318.[1/]

The cases at bar raise a number of questions virtually identical to issues that this Court has resolved definitively in the past. The question of abortion access--or protection from direct interference with the means of effectuating the abortion decision--is squarely presented by the requirements that all abortions after the first trimester be performed in hospitals;[2/]

1/ A well-defined line separates active or direct interference with the right recognized in Roe and governmental failure to provide abortions for all. See McRae; Maher v. Roe, 432 U.S. 464 (1977). See also Colautti v. Franklin, 439 U.S. 379, 386 n.7 (1979).

2/ All three cases now before this Court present challenges to hos-

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that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique to be used;[3/] that the abortion patient wait

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Footnote continued

pitalization requirements for all abortions performed after the first trimester.

3/ Plaintiffs below in Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172), challenge provisions of an Akron, Ohio city ordinance containing the requirements described in text accompanying notes 3-4.

twenty-four hours between giving her informed consent and the performance of an abortion;[4/] that a second physician attend the abortion of a viable fetus;[5/] and that pathology reports by qualified pathologists be prepared following all abortions.[6/] Like the two-doctor concurrence and hospital-accreditation requirements invalidated

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4/ See note 3 supra.

5/ Plaintiffs below in Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft, 483 F.Supp. 679 (W.D. Mo. 1980), aff'd in part, rev'd in part, 655 F.2d 848 (8th Cir.), on remand, 664 F.2d 687 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623), challenge provisions of a Missouri statute containing the requirements described in text accompanying notes 5-6.

6/ See note 5 supra.

in Doe and the spousal consent rule and saline amniocentesis ban overturned in Danforth, these restrictions do not entirely prohibit obtaining an abortion. Yet all of the limitations now before this Court, according to the records, make effectuating the abortion decision of adult women more onerous, more costly, more time-consuming, more difficult, and--sometimes--more hazardous.[7/]

7/ Courts have determined that mandatory waiting periods, like those imposed by the Akron ordinance, see note 4 and accompanying text supra, increase the health risks to the abortion patient by delaying the procedure as her pregnancy advances. See, e.g., Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 655 F.2d 848, 866 (8th Cir. 1981) (48-hour waiting period), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255

(Footnote continued on following page)

None of these enactments could even arguably be characterized as a mere failure to provide active governmental assistance, to be reviewed according to the analysis in the abortion-funding cases. See, e.g., Harris v. McRae, 448 U.S. 297 (1980). Instead, these enactments are state-created obstacles to abortion imposed through affirmative regulation of private conduct and policed with criminal

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Footnote continued

& 81-1623); Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981) (24-hour waiting period); Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980) (24-hour waiting period). Hospitalization requirements, see note 2 supra, may also increase the health risks of abortion. See Ashcroft, 655 F.2d at 856-57.

penalties for noncompliance. They treat abortion differently from any other medical service, overriding standard medical practice and individual professional judgment. They interfere directly with the prima facie right of privacy of adult women elaborated in Roe, and they call for review against the standard used by this Court in Roe and in all subsequent abortion cases involving direct interference with the constitutional right of privacy of adult women: strict judicial scrutiny.8/

8/ This Court's validation in Danforth of Missouri's written consent and recordkeeping requirements can easily be reconciled with the above con-

(Footnote continued on next page)

Footnote continued

clusions. The written consent requirement imposes no burden on the privacy right but simply verifies that the abortion decision is made by the individual to whom the protected privacy right belongs, the pregnant woman. The recordkeeping requirement, albeit for slightly different reasons, imposes "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship." Danforth, 428 U.S. at 81. The Court's treatment of both these issues is elaborated further in part II B infra.

II.

This Court must scrutinize the abortion regulations now before it against the single standard, strict judicial scrutiny, consistently applied to all regulations directly imposing any burden on the adult woman's privacy right; a more relaxed test allowing ad hoc evaluations of the degree of the burden inflicted by abortion regulations would undermine a fundamental constitutional right, conflict with this Court's precedents, and create a judicially unmanageable standard for all fundamental-rights cases.

A.

Under Roe v. Wade, the abortion regulations now before this Court must be narrowly drawn to advance one of two possible compelling state interests: maternal health (compelling only after approximately the end of the first trimester) and potential life (compelling only after fetal viability).

This Court carefully explained that the liberty recognized in Roe v. Wade, although neither absolute nor

unqualified, is a "fundamental right." 410 U.S. at 153-55. To withstand the strict judicial scrutiny evoked by such protected interests, any governmental restriction interfering with the right of an adult woman to terminate a pregnancy "may be justified only by a 'compelling state interest'" and "must be narrowly drawn to express only the legitimate state interests at stake." Id. at 155. See Carey v. Population Services International, 431 U.S. 678, 686 (1977). The abortion regulations at bar must be tested against this standard.

In Roe and its successors, this Court identified only two state interests that become sufficiently compel-

ling at particular points in pregnancy to meet this test. First, a state's interest in protecting potential life becomes sufficiently compelling to justify abortion restrictions narrowly designed to further that goal only after viability, the point of fetal capacity for meaningful extrauterine survival. Roe, 410 U.S. at 163.[9/]

Second, the interest a state may assert in protecting maternal health matures to "the 'compelling' point" only at "approximately the end of the first trimester" of pregnancy, id. at 163, because until that time--according

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9/ See also Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 63-65 (1976); Colautti v. Franklin, 439 U.S. 379 (1979).

to the medical literature available in 1973--"mortality in abortion may be less than mortality in normal childbirth," id; see id. at 149; Connecticut v. Menillo, 423 U.S. 9, 11 (1975). Restricting abortion during the first trimester because of the purported danger of the procedure would, therefore, only subject pregnant women to the greater health hazards posed by delivery, the inevitable end of an uninterrupted pregnancy. The logic of this conclusion necessarily transcends the particular timetable developed by this Court in 1973. Thus, as abortion techniques become more sophisticated, the comparative dangers of abortion at any point in pregnancy as opposed to child-

birth will change. The post-first-trimester hospitalization requirements raised by all three cases now before this Court must be examined in this light.

After this "compelling point," the Constitution allows states to enact abortion regulations that "reasonably [relate] to the preservation and protection of maternal health." Roe, 410 U.S. at 163. The reference to "reasonableness" here not is a departure from application of the "compelling state interest" test, but instead reflects the analysis used by this Court to ascertain whether that test, with its requirement of narrowly tailored enactments, was satisfied: Abortion regu-

lations that depart from established medical practices are insupportable on health grounds because they unnecessarily constrain the physician's exercise of his best medical judgment, recognized by this Court as the strongest safeguard of maternal health. See Doe v. Bolton, 410 U.S. 179, 192, 195, 197 (1973). They may therefore increase the risks of abortion without conferring any health benefits in return. They may also force women to undergo the often greater health risks of childbirth by limiting the availability of abortions. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 77-78 (1976). Such unnecessary abortion restrictions are,

as a result, unreasonable on health grounds and thus are not narrowly drafted to advance a compelling state interest in protecting maternal health.

Because neither the interest in preserving potential life nor the interest in protecting maternal health is compelling during the first trimester of pregnancy, throughout that stage "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." Roe, 410 U.S. at 163. This Court has rejected the argument that a state has any sufficiently compelling interests to limit an adult woman's

liberty to effectuate the abortion decision during the first trimester. See id. at 162-64.

B.

This Court's precedents dictate a two-step inquiry to ascertain whether the abortion regulations at bar are unconstitutional: do the regulations impose any burden at all on the abortion decision and its effectuation and, because these regulations directly impose such burdens, do they fail to satisfy the "compelling state interest" test?

In cases involving governmental interference with an adult woman's abortion decision or with her access to the means to effectuate that decision, this Court has never wavered from applying the "compelling state interest" test employed in Roe. See Carey v. Population Services International, 431 U.S. 678, 688 (1977) (same "compel-

ling state interest" test must be applied to restrictions on abortion access as to complete prohibitions). For example, Georgia's special hospitalization and accreditation regulations, unable to withstand this Court's strict judicial scrutiny because they applied indiscriminately even to the first trimester, fell in Doe v. Bolton, 410 U.S. 179, 194-95 (1973). Similarly, a number of Missouri abortion restrictions, including a spousal consent requirement and a ban on saline amniocentesis, were declared unconstitutional because they failed to prove necessary to advance either of the two compelling state interests identified in Roe. Planned Parenthood of Central Missouri

v. Danforth, 428 U.S. 52, 69 (1976) (spousal consent law impermissibly covers even first trimester); id. at 79 (saline amniocentesis ban "fails as a reasonable regulation for the protection of maternal health").

This Court has applied a less stringent test to abortion laws only where the state has not acted affirmatively at all to impinge on a woman's right to obtain an abortion or where a regulation does not interfere--even to a minimal extent--with that right. Thus, for example, this Court has not applied the "compelling state interest" test to governmental failure to fund abortions for the indigent, inaction imposing "no restriction on access to

abortions that was not already there." Maher v. Roe, 432 U.S. 464, 474 (1977); see Harris v. McRae, 448 U.S. 297 (1980). Similarly, simple written-consent and recordkeeping requirements have not evoked this Court's strictest scrutiny because these regulations in no way interfere with a woman's ability to decide to obtain an abortion and to effectuate that decision. A simple[10/] written-consent requirement merely assures that the abortion deci-

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10/ The Court cautioned in Danforth that elaborate or detailed informed-consent requirements "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession," thus infringing the patient's right of privacy. 428 U.S. at 67 n.8.

sion has been made by the pregnant woman herself, the individual to whom the constitutional right of privacy belongs, see note 8 supra, while mandated recordkeeping of the sort considered in Danforth has "no legally significant impact or consequence on the abortion decision or on the physician-patient relationship," Danforth, 428 U.S. at 81 (emphasis added). See Whalen v. Roe, 429 U.S. 589, 607 (1977) (Brennan, J., concurring) (absent a deprivation of constitutionally protected liberty, state need not show law necessary to compelling state interest).

This Court's precedents thus unequivocally dictate a two-step inquiry for ascertaining the constitutionality

of a challenged abortion regulation. First, a court must examine whether or not the regulation is state action imposing any burden at all on the right to obtain an abortion. The question here is not one of degree but simply whether the regulation affirmatively imposes any legally cognizable burden. If it does not, then the analytical framework developed in Roe does not govern. See Danforth; Maher; McRae. If, however, the regulation imposes any burden on the right recognized in Roe, then, as a second step, strict judicial scrutiny must be applied to determine whether that burden is undue--that is, whether it is properly justified by

a compelling state interest and sufficiently narrowly tailored to further that goal. See McRae, 448 U.S. at 314; Maher, 432 U.S. at 473-74.

Roe made plain the principles controlling during this second step of the inquiry: the lack of any compelling state interest during the first trimester of pregnancy, the compelling character of a state's interest in protecting maternal health only after the first trimester,[11/] and the compelling character of a state's interest in preserving potential life only after fetal viability. 410 U.S. at 163-64.

As noted earlier, all of the regu-

11/ But see pages 23-24 supra.

lations now before this Court interfere directly with the right recognized in Roe; according to the records, they significantly burden the abortion decision and its effectuation by making termination of a pregnancy more onerous, more costly, more time-consuming, more difficult, and--sometimes-- more hazardous.12/

Under the strict judicial scrutiny that must therefore govern, all of the measures applicable to abortions sought by adult women during the first trimester must fall because neither state interest identified in Roe is sufficiently compelling during that stage

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12/ See note 7 supra.

to support such restrictions. All of the first-trimester regulations challenged here are, consequently, "unduly burdensome." See McRae, 448 U.S. at 314, Maher, 432 U.S. at 473-74 (Roe doctrine "protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy"). These impermissible first-trimester regulations include the requirements that the attending physician personally inform the patient of facts relating to her pregnancy, the abortion procedure, fetal characteristics, agencies available to assist her, appropriate postoperative care, and the risks of the abortion technique

to be used;[13/] that the abortion patient wait twenty-four hours between the giving of her informed consent and the performance of an abortion;[14/] and that pathology reports by qualified pathologists be prepared after all abortions.[15/]

The measures before this Court regulating abortions after the first trimester must also be tested against the Roe standard. This Court must determine whether Missouri, Virginia and Akron, Ohio have established that

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13/ See note 3 supra.

14/ See notes 3-4 supra.

15/ See notes 5-6 supra.

their hospitalization requirements for all abortions performed after the first trimester are necessary to protect maternal health and that those requirements are drafted narrowly to achieve that legitimate goal.16/ Current medical knowledge regarding the relative safety of various abortion techniques and the comparative risks of childbirth

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16/ See note 2 supra. Because the constitutional right at stake is fundamental, the state (or city) bears the burden of satisfying the "compelling state interest" test. See, e.g., Roe, 410 U.S. at 155. See also Moore v. City of East Cleveland, 431 U.S. 494, 499 (1977) (plurality opinion). The court in Simopoulos v. Commonwealth, 277 S.E.2d 194, 204 (Va. 1981), probable jurisdiction noted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (No. 81-185), thus incorrectly presumed the constitutionality of Virginia's mandatory hospitalization law.

and abortion must figure in this analysis, as it has in this Court's precedents. See Roe, 410 U.S. at 163; Danforth, 428 U.S. at 76-79; part II A supra. For example, the finding by the district court in Ashcroft, affirmed by the court of appeals, regarding the comparable safety of D & E procedures inside and outside hospitals must be a determinative consideration. Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 664 F.2d 687, 690 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

Similarly, Missouri's law mandating the attendance of a second physi-

cian at the abortion of a viable fetus[17/] will survive the required strict scrutiny only if determined to be narrowly tailored to advance the state's interest in preserving potential life after the relevant "compelling point," fetal viability. See Colautti v. Franklin, 439 U.S. 379 (1979). The district court, affirmed by the court of appeals, found this law unconstitutionally overbroad because it covered even those abortions which maternal health considerations required to be performed by means incompatible with

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17/ See note 5 supra.

fetal survival.[18/] Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, 655 F.2d 848, 865-66 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623).

In sum, Roe and its successors dictate the controlling standard of review, strict scrutiny, that must apply to the regulations challenged here as well as the identity and scope of the two state interests that may be sufficiently compelling to support narrowly drawn abortion limitations.

18/ Under Roe, even though a state may generally go so far as to proscribe post-viability abortions, it cannot do so in cases where maternal life or health would be jeopardized. 410 U.S. at 164, 165.

C.

Only the "compelling state interest" test--applied here and in all fundamental-rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates.

The reasons are plain why this Court will continue to adhere to the two-step inquiry dictated by its precedents, instead of resorting to a balancing test[19/] or sliding

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19/ Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1200 (N.D. Ohio 1979) (defining balancing test). See id. at 1207 (applying balancing test).

The district court in the Akron case (Nos. 81-746 & 81-1172) used a balancing test on the theory that only

(Footnote continued on following page)

scale[20/] based upon ad hoc evaluations

Footnote continued

an absolute prohibition or veto of the abortion decision must be justified by a compelling state interest and narrowly drawn to further that goal. "Lesser" invasions of the privacy right require a court simply to weigh the "degree" of interference against "any valid state interest furthered by such" regulation. Id. at 1200.

The district court's erroneous conclusion about the appropriate standard of review stems from its effort to read this Court's treatment of direct interference with an adult woman's right of privacy together with the opinions in two very different areas: cases concerning the privacy rights of minors, where this Court has applied a distinct standard of review, see part III infra, and the abortion-funding cases, where the lack of any active governmental interference with the abortion decision eliminates the need for strict scrutiny, see, e.g., Harris v. McRae, 448 U.S. 297 (1980).

20/ Judge Kennedy, concurring in part and dissenting in part in the Akron

(Footnote continued on following page)

of the degree of the burden arguably imposed by each and every abortion regulation.

Footnote continued

case (Nos. 81-746 & 81-1172), fashioned a sliding scale under which the intensity of the judicial scrutiny is determined by the degree of the burden an abortion regulation imposes. Unlike the district court, see note 19 supra, Judge Kennedy would not confine strict scrutiny to absolute prohibitions and vetoes of the abortion decision. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1215 (6th Cir. 1981) (Kennedy, J., concurring and dissenting). Unlike the majority of the court of appeals, however, Judge Kennedy would eschew the two-step inquiry and would decline to apply strict scrutiny to all restrictions imposing any burden on the abortion decision. Id. n.5.

The basic flaw in Judge Kennedy's analysis is the same as that in the district court opinion: an attempt to unify several clearly and explicitly distinguished lines of cases. See note 19 supra.

First, as this Court emphasized decades ago, "it is the character of the right, not of the limitation, which determines what [constitutional] standard governs the [legislative] choice." Thomas v. Collins, 323 U.S. 516, 530 (1945). That principle remains sound law today. See Schad v. Borough of Mount Ephraim, 452 U.S. 61, 68 (1981). Constitutional rights properly deemed fundamental, such as the right to decide to terminate a pregnancy and the right to effectuate that decision, require the vigorous protection from governmental intrusions that only strict judicial scrutiny, applied to every direct interference or burden, affords.

The right of privacy, in particular, which limits the government's power to intervene in intensely personal decisions and their effectuation, demands the most stringent standard of judicial review. A matter as sensitive as whether or not to terminate a pregnancy--fraught as it is with intractable questions about the beginning of human life--simply cannot be left to majoritarian resolution, under which any number of impediments to abortion might be reasonable if predicated upon one of several competing and ultimately unverifiable theories of human existence. This Court has thus recognized that the Fourteenth Amendment's due process clause prima facie guarantees

to the individual the power to resolve such questions. Roe v. Wade, 410 U.S. at 162 (Texas may not override the rights of the pregnant woman by adopting one theory of life); Bellotti v. Baird, 443 U.S. 622, 655 (1979) (Stevens, J., concurring) ("It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign...."); Tribe, The Supreme Court, 1972 Term--Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1 (1973).

This Court has carefully crafted the "compelling state interest" test

so that truly overriding governmental concerns, if advanced by narrowly drafted laws, can impinge on fundamental liberties, including the right of privacy. Under such circumstances, a deprivation of liberty is constitutionally justified, and the ultimate judgment will be that that deprivation is not "unduly burdensome." See generally Note, Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance, 57 B.U.L. Rev. 462 (1977). To suggest, as some lower courts have, that strict scrutiny controls only when the burden on the privacy right is thought, in the first

instance, to be "undue"[21/] is to turn this Court's preservation of individual constitutional rights on its head. Lowering the standard of review for

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21/ See, e.g., Leigh v. Olsen, 497 F.Supp. 1340, 1343, 1346 (D.N.D. 1980) (regulations not unduly burdening abortion decision need be only rational; statute requiring patient to be informed of alternatives to abortion bears reasonable relation to informed consent and state's preference for childbirth). But see Charles v. Carey, 627 F.2d 772, 777 (7th Cir. 1980): "[T]he term 'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny." Other courts have adopted this well-reasoned statement of the law. E.g., Planned Parenthood Ass'n of Kansas City, Inc. v. Ashcroft, 655 F.2d 848, 855 (8th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-1255 & 81-1623); Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1204 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

arguably "lesser" infringements would eviscerate the protection of fundamental rights by sustaining such infringements even if overbroad or unrelated to a compelling interest.22/

Moreover, because the operative element in such analysis would be the perceived degree of the burden imposed,

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22/ For example, the district court in the Akron case sustained several first-trimester abortion regulations (including a detailed "informed-consent" requirement and a mandatory twenty-four-hour waiting period) because they furthered "valid state interests in maternal health and welfare" without cumulatively making abortion "so much more expensive" as to effect a veto of a woman's decision. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1207 (N.D. Ohio 1979), aff'd in part, rev 'd in part, 651 F.2d 1198 (6th Cir. 1981), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172).

no unique feature of abortion litigation would confine this variable standard of review to those cases alone; all fundamental rights would be equally susceptible of such diluted protection. See Appleton, Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis, 81 Colum. L. Rev. 721, 752-53 (1981).

Apart from the precious and delicate nature of the privacy right and the resulting need for heightened judicial protection, the analytical framework that this Court has consistently followed since Roe must be retained because it is the only one capable of

coherent judicial administration. Use of a balancing test[23/] or a sliding scale[24/] in order to set a standard of review is entirely unworkable for two reasons.

First, it is circular. It purports to prescribe a standard of review that will guide the consideration of various factors but in truth it brings all those factors into play in setting the standard.[25/] Such circularity is obviously untenable and could only raise questions about the foundation and consistency of the decisions rest-

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23/ See note 19 supra.

24/ See note 20 supra.

25/ See note 21 supra.

ing on such reasoning. In contrast, the Roe analysis is entirely straightforward. And whatever may be said about the outcome-determinative quality of strict judicial scrutiny in other contexts,[26] this Court's identification in Roe of two state interests that eventually do become compelling demonstrates that strict scrutiny in abortion cases does not "merely [announce] an inevitable result"[27]--unconstitution-

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26/ See Gunther, The Supreme Court, 1971 Term--Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972).

27/ Widmar v. Vincent, 102 S.Ct. 269, 279 n.3 (1981) (Stevens, J., concurring); Illinois State Bd. of Elections v. Socialist Workers Party, 440 U.S. 173, 188-89 (1979) (Blackmun, J., concurring).

ality--but instead signals an adjustment between protected rights and truly overriding governmental concerns.

Beyond its circularity, a balancing test or sliding scale is ultimately standardless. How are the degrees of interference or burden to be determined? Under a balancing test, how much additional cost[28/] must be imposed or how great must be the additional health risks before the burden of an abortion regulation outweighs, for example, a pre-viability state interest in protecting potential life? Or is "burdensomeness" measured by the number of abortions the regulation actually curtails? Under the sliding scale, how much additional cost, how great the

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28/ See note 22 supra.

health risks, or how many foregone abortions would be necessary before strict scrutiny would govern?

Instead of according more deference to state and local governments, such weaker standards of review--with their intrinsic indeterminacies--would only multiply the number of federal-state clashes, as federal courts at all levels struggled to implement that regime. The various lower courts would undoubtedly reach conflicting conclusions about the "burdensomeness" of all manner of regulations, thereby increasing the uncertainty in fundamental-rights cases generally and, in particular, compelling this Court's continuing role as the arbiter of the permissibility of every state's and every city's abortion laws.

III.

Because of the unique status of children under the law, this Court has used a special standard of review for regulations of abortions for minors, requiring states to allow mature minors to make their own abortion decisions and to free from parental involvement all those minors whose best interests so demand.

Children have occupied a unique status throughout this Court's constitutional adjudication. As a plurality of this Court observed in Bellotti v. Baird, 443 U.S. 622 (1979): "Children have a very special place in life which law should reflect. Legal theories and their phrasing in other cases readily lead to fallacious reasoning if uncritically transferred to determination of a State's duty towards children." Id. at 633-34 (plurality opinion)

(quoting May v. Anderson, 345 U.S. 528, 536 (1953) (Frankfurter, J., concurring)). Hence, "constitutional principles [must] be applied with sensitivity and flexibility to the special needs of parents and children." Bellotti, 443 U.S. at 634 (plurality opinion).

Certainly, the Constitution protects minors as well as adults. See, e.g., In re Gault, 387 U.S. 1, 13 (1967). Moreover, as this Court has recognized, adolescent pregnancy is a widespread and personally devastating occurrence.[29/] Yet because of the

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29/ See Michael M. v. Superior Court, 450 U.S. 464, 470-71 (1981) (plurality opinion); id. at 479

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unique status of children under the law, this Court has applied a special standard of review in cases examining the privacy rights of minors: "whether there is any significant state interest [supporting the regulation] that is not present in the case of an adult." Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 75 (1976); Carey v. Population Services International, 431 U.S. 678, 693 (1977) (plurality opinion). As a plurality of this Court explained in Carey, 431 U.S. at 693 n.15:

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(Stewart, J., concurring); id. at 481-82 (Blackmun, J., concurring); Carey v. Population Servs. Internat'l, 431 U.S. 678, 696 & n.21 (1977) (plurality opinion).

> This test is apparently less rigorous than the "compelling state interest" test applied to restrictions on the privacy rights of adults. Such lesser scrutiny is appropriate both because of the States' greater latitude to regulate the conduct of children, Prince v. Massachusetts, 321 U.S. 158 (1944); Ginsberg v. New York, 390 U.S. 629 (1968), and because the right of privacy implicated here is "the interest in independence in making certain kinds of important decisions," Whalen v. Roe, 429 U.S. 589, 599-600 (1977), and the law has generally regarded minors as having a lesser capability for making important decisions. See, e.g., Planned Parenthood, 428 U.S., at 102 (Stevens, J., concurring in part and dissenting in part).

This Court's repeated emphasis of the long held and deeply rooted doctrine according minors a unique status under the law, see Bellotti; Danforth, 428 U.S. at 74-75; Ginsberg v. New York, 390 U.S. 629, 638-41 (1968); Prince v. Massachusetts, 321 U.S. 158,

170 (1944), explicitly refutes any theory, such as that embraced by Judge Kennedy, writing separately in the Akron case, that all of this Court's privacy precedents -- those concerning minors as well as adults -- should be read together as the source of a universal, sliding-scale standard of review for abortion regulations, whether applicable to minors or adults. See Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1211-15 (6th Cir. 1981) (Kennedy, J., concurring and dissenting), cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). See also Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1198-1200 (N.D. Ohio 1979). This

Court's precedents plainly recognize that minors' abortion rights pose problems distinct from those affecting adults and demand a distinct standard of review.

This Court has identified three concerns uniquely relevant to minors: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." Bellotti, 443 U.S. at 634 (plurality opinion). Although these special concerns will not support a state-granted parental veto over a minor's abortion decision, Danforth, 428 U.S. at 74-75, a majority of the Justices of this Court would approve a more narrowly drafted statute allowing minors judicially determined to be mature to make their own

abortion decisions while requiring immature minors to obtain a consent-substitute, parental permission or judicial authorization predicated upon a determination of the minor's best interests. See Bellotti, 443 U.S. at 643-44 (plurality opinion for four Justices); id. at 656-57 (White, J., dissenting) (expressing approval of even absolute parental consent requirement).

Similarly, this Court has validated a parental notification requirement because it served not only "the important considerations of family integrity and protecting adolescents" but also "a significant state interest by providing an opportunity for parents to supply essential medical and other information to a physician." H.L. v. Matheson, 450 U.S. 398, 411 (1981). This Court did not, however, extend

that holding to mature or emancipated minors or to immature minors showing such notification detrimental to their best interests. 450 U.S. at 407 & n.14.

The abortion regulations at bar pertinent to minors must be tested against the special standard of review and in light of the special concerns for minors and their parents articulated by this Court in the past. Under these guidelines, the district court and the court of appeals correctly held unconstitutional Akron's requirement of parental or judicial consent for abortions for all minors under the age of fifteen. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172, 1201 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198, 1205 (6th Cir. 1981),

cert. granted, 50 U.S.L.W. 3934 (U.S. May 25, 1982) (Nos. 81-746 & 81-1172). This provision--enacted before this Court's decision in Bellotti--impermissibly allows parents or, alternatively, a court to veto the abortion choice of even a minor under the age of fifteen years who is sufficiently mature to reach that decision herself. See Bellotti, 443 U.S. at 643-44 (plurality opinion). Moreover, it contains no procedural safeguards that ensure an abortion for an immature minor under the age of fifteen years whose best interests require termination of her pregnancy without any parental involvement.30/ See id. at 651. See also

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30/ Where, as here, the class addressed consists of pregnant minors below the age of fifteen, the procedures

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H.L., 450 U.S. at 413-20 (Powell, J., concurring, joined by Stewart, J.) (some minors' best interests require exemption from parental notification); id. at 446, 452-53 (Marshall, J., dissenting, joined by Brennan and Blackmun, JJ.) (same).

Without such exceptions and safeguards, this provision of the Akron ordinance fails as unconstitutionally overbroad.

CONCLUSION

For all of the reasons stated, the 85 amici respectfully submit that the prima facie privacy right recognized

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purportedly offering a meaningful alternative to parental involvement must be clearly described and easily understood. This provision of the Akron ordinance, referring only to "a court having jurisdiction," fails this test. See 479 F. Supp. at 1201.

in Roe v. Wade includes freedom to effectuate the abortion choice without government interference; that the strict judicial scrutiny used in Roe and its progeny must apply to all enactments at bar regulating abortion procedures for adult women; and that the special standard of review articulated by this Court in recognition of the unique status of children under the law must apply to the enactments at bar regulating abortion procedures for minors.

Respectfully submitted,

Professor Susan Frelich Appleton
Washington University
School of Law
St. Louis, Missouri 63130

Professor Paul Brest
Stanford Law School
Stanford, California 94305

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CASE NO. 81-746 and 81-1172

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1982

CITY OF AKRON, ET. AL.,

Petitioners

— vs —

AKRON CENTER FOR REPRODUCTIVE HEALTH, ET. AL.

Respondents

PETITION FOR WRIT OF CERTIORARI FOR THE SIXTH CIRCUIT COURT OF APPEALS

BRIEF AMICUS CURIAE FOR LAWYERS FOR LIFE

Of Counsel:
Mary Ann Johanek
Joseph Meissner
Earl Krock
Thomas Kondzer
Dan Murray
Art Foth

Legal Assistants:
James Crawford
Yolanda Clancy

Ronald J. Suster, Esq.
Counsel of Record
LAWYERS FOR LIFE
655 Broadway Avenue
Cleveland, Ohio 44146
Tele: 216-232-5765

Attorney for Amicus Curiae,
Lawyers for Life

QUESTIONS PRESENTED

1. UPON WHAT BASIS CAN A STATE ACT IN ORDER TO PROTECT THE "ALPHA"?(*)

2. HOW CAN THE STATE'S INTEREST IN PROTECTING ALPHA THROUGH LEGISLATION BE RECONCILED WITH THE RIGHT OF PRIVACY INVOLVED IN TERMINATING A PREGNANCY?

(*) "Alpha" is a term that has been suggested as a neutral and unemotional way of referring to the developing biological entity within a woman's body during pregnancy. This term is used throughout this Brief. (See Nathanson, within, 178-9.)

TABLE OF CONTENTS

QUESTIONS PRESENTED ..... (i)

TABLE OF AUTHORITIES ..... (iii)

INTEREST OF AMICUS CURIAE..... 1

INTRODUCTION..... 3

ARGUMENT..... 4

I. AS SCIENTIFIC KNOWLEDGE ABOUT ALPHA INCREASES AND AS MEDICAL CAPABILITIES TO PROVIDE FOR ALPHA MULTIPLY, CORRESPONDINGLY THE POWER OF THE STATE TO PROTECT ALPHA SHOULD BE ENLARGED.... 4

II. SO LONG AS STATE LEGISLATION PROTECTING ALPHA DOES NOT UNDULY LIMIT THE RIGHT OF PRIVACY INVOLVED IN ABORTION, SUCH LEGISLATION SHOULD NOT BE STRUCK DOWN AS UNCONSTITUTIONAL..... 13

CONCLUSION..... 18

APPENDIX 1 19

CERTIFICATE OF SERVICE 30

TABLE OF AUTHORITIES

Cases: Pages

Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198 (6th Cir. 1981), cert granted, Nos. 81-746 and 81-1172 ..... 3, 13

Colautti v. Franklin, 439 U.S. 379, 99 S.Ct. 675 (1979)..... 6

Doe v. Bolton, 410 U.S. 179, 93 S.Ct. 739 (1973)..... 4, 8, 13, 15

Planned Parenthood v. Ashcroft, 655 F.2d 848 (8th Cir. 1981), cert granted, Nos. 81-1255 and 81-1623..... 3, 13

Roe v. Wade, 410 U.S. 113, 164, 93 S.Ct. 705, 732 (1973)..... 4, 5, 6, 8, 11, 12, 13, 15

Sierra Club v. Morton, 405 U.S. 727, 92 S.Ct. 1361 (1972)..... 17, 18

Simopoulos v. Virginia, 221 Va.2d 1059, 277 S.E.2d 194 (1981), petition granted, No. 81-185..... 3, 13

Other Authorities:

Nathanson, M.D., Bernard, Aborting America (New York: Doubleday & Company, Inc., 1979) and edition published by Life Cycle Books, Toronto, Ontario, Canada..... i, 5, 8, 9, 10, 11

INTEREST OF AMICUS CURIAE

Lawyers for Life is an association of attorneys in Ohio who are dedicated to promoting respect for every human life. Formally begun in 1975, our organization has worked diligently to protect the rights of pregnant women and their unborn offspring.

Our members have represented unwed pregnant mothers in their legal efforts to obtain the necessary support and maternal expenses from the fathers of their yet-to-be-born babies. We have worked with other groups who provide counseling and assistance to pregnant women and their families. We have provided legal materials and expert testimony to both local and state legislative bodies on such issues as euthanasia, abortion, infanticide, the legal definition of death, and the rights of pregnant women. Our members have also been active in the courts, both State and Federal. We have provided expert

witnesses, argumentation, and legal briefs to assist the courts in their decision on these life issues. All of this legal work is done without charge to anyone. None of our members receive any payment for their work.

Our organization is particularly concerned with this present litigation before this Court. Any decision by this Court will have a profound impact upon the activities of our members and their efforts to assist pregnant women and their offspring. The quality of medical care as well as the medical advice and counseling that our clients will receive will also be affected by what this Court does. Finally, no one can deny the leadership role of this Court in shaping the legal and medical standards of our nation in dealing justly with the rights of the pregnant woman and the developing life she carries within. For these reasons we file this brief.[1]

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[1] The parties have consented to our filing this amicus brief. Pursuant to Rule 42(2) we are filing their letters with the Clerk of this Court.

INTRODUCTION

This case, City of Akron, et al, vs. Akron Center for Reproductive Health, et al, concerns an extensive ordinance passed by the City of Akron relating to pregnancy terminations. This Akron case raises the general question of the rights and interests of a State and its sub-divisions to legislate on abortion, especially those performed during the first trimester of alpha's existence. The Akron case shares this general question with two other cases now before this Court, that is, Planned Parenthood v. Ashcroft (81-1255 and 81-1623) and Simopoulos v. Virginia (81-185).

The position and argument of Lawyers for Life in this case can be summarized as follows. The alpha does have a value which can be and should be protected by law. As our scientific knowledge about alpha increases and as medical capabilities multiply to provide for alpha, correspondingly both the duty and the power of

the State to protect alpha are enlarged. While such protection is now subject to the right of privacy involving an abortion, the Supreme Court's decisions of Roe v. Wade, 410 U.S. 113 (1973), and Doe v. Bolton, 410 U.S. 179 (1973), should not be interpreted to foreclose the State's concerns about alpha. How a State might legislate to protect alpha while at the same time respecting the reproductive rights of women will be addressed in the latter part of this brief.

ARGUMENT

I. AS SCIENTIFIC KNOWLEDGE ABOUT ALPHA INCREASES AND AS MEDICAL CAPABILITIES TO PROVIDE FOR ALPHA MULTIPLY, CORRESPONDINGLY THE POWER OF THE STATE TO PROTECT ALPHA SHOULD BE ENLARGED.

During the Roe case, the Defendant State made the argument that laws prohibiting abortion could be justified on the basis of when life begins. This Court responded as follows:

> Texas urges that, apart from the Fourteenth Amendment, life begins at conception and is present throughout pregnancy, and that, therefore, the State has a com-

> pelling interest in protecting that life from and after conception. We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer. (Emphasis supplied.) 410 U.S. at 159, 93 S.Ct. at 730.

While then finding that a State could not override the rights of a pregnant woman by adopting one theory of life over another, the Court did declare that the State still had an "important and legitimate interest in protecting the potentiality of human life" in addition to the State's interest in protecting the woman's health. (410 U.S. at 162, 93 S.Ct. at 731.)

The Court concluded that this State interest became compelling at the point when alpha became "viable." The problem with the concept of viability has been pointed out by a number of commentators. "The concept is fluid," writes Dr. Bernard Nathanson, M.D., "and is constantly being pushed backward." (Nathanson, M.D., Bernard, Aborting America (New York: Doubleday & Company,

Inc., 1979), p. 208.) On the other hand, and this is the crucial idea, the Court has tied the State's power to protect alpha with the development of man's knowledge. Furthermore, Roe suggested, by its definition of "viability," that the State's power to prohibit abortion, depended upon medical science's capabilities to help alpha live outside the womb. "Viable," according to the Court, meant when alpha was "potentially able to live outside the mother's womb, albeit with artificial aid." (Emphasis supplied, 410 U.S. at 160, 93 S.Ct. at 730.) (2)

What, then, has science learned about alpha since the Court's 1973 decisions? What new capabilities has medicine discovered for

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(2) The decision, Colautti v. Franklin, 439 U.S. 379, 99 S.Ct. 675 (1979), tends to undercut some of this analysis. While the majority's concern about problems of "vagueness" and "scienter" in Colautti are understandable, what seems to be missing is a recognition of the State's interest in safeguarding human life. When the physician decides to perform an abortion and alpha could survive, it hardly seems unreasonable for the State to provide a strong zone of protection around alpha, assuming little or no risk to the woman.

treating alpha?

Answers to these questions can be found in Dr. Bernard Nathanson's book which has already been cited. In addition, another reason for why this Court as well as others involved in the abortion controversy should examine what Dr. Nathanson has to say is because of his immense experience in this area. A prominent obstetrician-gynecologist in New York City, the only doctor among those who originally founded and ran the National Association for Repeal of Abortion Laws (N.A.R.A.L.), and one-time Director of the largest abortion clinic in the Western world, Dr. Nathanson sums up his present views in these words:

> There are 75,000 abortions in my past medical career, those performed under my administration or that I supervised in a teaching capacity, and the 1,500 that I have performed myself. The vast majority of these fell short of my present standard that only a mother's life, interpreted with appropriate medical sophistication, can justify destroying the life of this being in inner space [the alpha] which is becoming better known to us with each passing year. I now regret this loss of life. I thought the abortions were right

> at the time; revolutionary ethics are often unrecognizable at some future, more serene date. The errors of history are not recoverable, the lives cannot be retrieved. One can only pledge to adhere to an ethical course in the future. (Nathanson, at 248-9.)

What brought Dr. Nathanson to a deeper understanding about abortion? His earlier abortion crusade had been built upon his experiences. "I had been terribly disturbed by the injustice and hypocrisy of the '60's, the disparity between rich and poor...," he states, "I had seen the victims of self-abortion and hack abortionists." (Nathanson, at 161.)

At the same time of the Roe and Doe decisions in 1973, for whose rulings Dr. Nathanson and others had so diligently labored, he supervised the establishment of a sophisticated perinatology unit at Woman's Hospital in New York city. Here he used advanced medical equipment and fetal electronic heart monitoring machines. "What began to erode the N.A.R.A.L. dogmas," writes Dr. Nathanson, "was the daily realization of the 'intrauterine patient' that we were treating,

tracing, sampling, and observing through electric monitoring or the flickering images on an ultrasonic screen." (Nathanson, at 161.)

The alpha as a "patient" is a new concept absent so far from the Court's decision. "One of the great underreported medical revolutions of our time is this field of perinatology, the intensive investigation and treatment not only of the newborne baby but of the fetus...." (Nathanson, at 160.) At the same time that abortions have multiplied in the past decade, there has been an explosion of knowledge about alpha and the latter's intrauterine existence. In 1976 alone three English-language journals began publication, specializing in fetal research: Monographs in Fetal Physiology, Reviews in Perinatal Medicine, and, the best-known, Perinatal Medicine. (Nathanson, at 160.)

All of this had an impact upon Dr. Nathanson's abortion views:

> This evolution of my thinking will sound incredible to many. I was generally aware of these biological developments

> during the years of my abortion crusade. Three things happened. First, I reflected again on the older knowledge in perinatology. Second, new data were reported all the time. Third, and most important, I opened myself up to the data. When one is caught up in a revolutionary fervor, one simply does not want to hear the other side and filters out evidence without realizing it. (Nathanson, at 161.)

It is not possible in this brief to review all of the new information that science has provided us on alpha. In one chapter of his book, Dr. Nathanson does furnish an excellent summary of what we now know. This has been reproduced as Appendix 1 and attached to this brief. The following paragraph from the Appendix does give us a view of alpha near the end of the first trimester which may conflict with our older idea of a relatively inert unintegrated entity:

> By the twelfth embryological week, when brain structure is essentially complete, alpha is spontaneously able to kick its legs, turn its feet, curl and fan its toes, move its thumbs, make a fist, bend its wrists, turn its head, squint, frown, open its mouth, suck its thumb, swallow amniotic fluid, and make inhaling-exhaling motions (though air, of course, is not inhaled until birth.) (Nathanson, at 201.)

Besides this new knowledge, science has been able to push back significantly the time at which alpha may be born and survive, though, of course, with artificial aid. In Roe, the Court had placed viability at about seven months or 28 weeks, but the Court did admit it might occur earlier, even at 24 weeks. (410 U.S. at 160, 93 S.Ct. at 730.) Actually, the more correct measure is not so much weeks, but "that all discussion of viability and survival rates must be based upon weight in grams...." (Nathanson, at 208.) Thus 28 weeks, the Court's criterion in Justice Blackmun's decision, is equivalent to 1,000 grams weight for alpha. By the time of Dr. Nathanson's book only six years after Roe, substantial changes had occurred:

> ....Blackmun's "viability" figures have essentially vanished at St. Luke's Hospital Center, where I practice. During 1977, six of nine infants admitted to the Special Care Nursery in the 751-1,000 gram category survived, a 66.7 per cent rate. One of the five in the 501-750 gram category lived, a 20 per cent survival rate. (Nathanson, at 212.)

Advances continue and the concept of viability

becomes essentially a measure of our medical technology rather than any intrinsic reflection of alpha.

If the Roe and Doe decisions are indeed based upon our scientific knowledge and capabilities regarding alpha, then the courts must be willing to re-examine their conclusions of law in light of the expanding information medicine now possesses. This may well result in the drawing of new lines as well as recognizing the legitimacy of the State's concern and interests in protecting alpha even in situations involving the right to privacy and abortion. Any other approach to the relationship between law and humanity's developing knowledge and capabilities threatens not only the adaptability of our legal system, but also contributes to the further erosion of our traditional respect for the paramount value of human life. This respect can only be maintained if our society and courts safeguard human life, even at the penumbra, whether in the alpha at the very beginning, or at edge of death, or weighed

down by some crushing disability or handicap.

II. SO LONG AS STATE LEGISLATION PROTECTING ALPHA DOES NOT UNDULY LIMIT THE RIGHT OF PRIVACY INVOLVED IN ABORTION, SUCH LEGISLATION SHOULD NOT BE STRUCK DOWN AS UNCONSTITUTIONAL.

In the Akron case, as well as in the other two cases of Planned Parenthood v. Ashcroft and Simopoulos v. Virginia, this Court is confronted with both State and local legislation affecting the performance of abortions. Our brief proposes that this Court consider each of the challenged provisions in light of our expanding knowledge of alpha and our growing abilities to treat alpha as a "medical patient." Our position, as suggested by Dr. Nathanson, is that Roe and Doe are meant to protect a right of privacy, not to mandate recognition of someone's right--whether the pregnant woman or the attending physician--to a dead alpha.

Thus if an abortion can be performed, freeing the woman of a troubling pregnancy, without causing

alpha's death, then there appears to be no reason why a State could not provide legal protection to assist alpha in surviving. This assumes, of course, that such an abortion procedure results in no unreasonable harm or risks to the pregnant woman. Given the increasing medical capability to care for alphas, the State would be able to protect them at an earlier and earlier stage in their development.

Certainly, in order to help these "viable" alphas to survive, a second doctor as well as the necessary technological equipment must be available. The transplanting of organs from a "dead" patient to a recipient is an analogous situation in which the donor's medical team is separate from the recipient's. The abortion situation involving a "viable" fetus presents similar considerations.

It must be conceded, however, that most abortions today involve alphas for whom science does not yet have the technology to insure survival. Are there laws which a State might pass in the interest of safeguarding alpha without at the

same time infringing upon the right of privacy established in Roe and Doe?

One way would be by requiring that the pregnant woman be provided with information about alternative ways of dealing with a problem pregnancy. With information about all the alternatives, the woman and her attending physician are in a much better position to make a decision.

Another means the State might employ to protect alpha would be to insure that the pregnant woman had sufficient knowledge about the existence and scientific attributes of alpha. Surely, the law cannot take any satisfaction in a situation where a woman terminates a pregnancy in ignorance about the qualities of alpha, only to learn of these afterward. Furthermore, for this alpha, there will be only this one opportunity for the State to protect alpha's existence through providing the pregnant woman with information which might lead to a choice to continue the pregnancy. Our laws already require in other

situations that participants be furnished with information before exercising a choice. These include borrowing money, purchasing a house, responding to police interrogation, making a plea to a criminal charge, and so on. Given the finality of abortion for this alpha, legislation mandating and specifying informed consent appears defensible if for no other reason than defending human life at its penumbra.

A further means a State could employ would be to establish minimal waiting periods between the time when a pregnant woman is informed regarding alpha and when the abortion takes place. Not only is alpha's existence protected during this period, but there is less likelihood that a decision to terminate will be undertaken in haste and without adequate time to consider all the alternatives. So long as such waiting periods do not endanger the woman's health, it is hard to understand why any would oppose these. (Some opponents of these waiting periods cite time and financial problems. Yet if these

arguments were employed in other situations of life-or-death, it is hardly likely that anyone would listen to them.)

Undoubtedly, many other arguments can and will be made on behalf of the various provisions in Akron's law regarding abortion as well as those laws of Missouri and Virginia in the pertinent cases. In no way does this brief deny the importance or truth of those arguments. Our concern is simply that this Court take cognizance of the claims and interests of alpha. Such a request is not unlike the eloquent argument urged by Mr. Justice Douglas, dissenting in Sierra Club v. Morton, 405 U.S. 727, 92 S.Ct. 1361 (1972). "Contemporary public concern," he wrote, "for protecting nature's ecological equilibrium should lead to the conferral of standing upon environmental objects to sue for their own preservation." (405 U.S. at 741-2, 92 S.Ct. at 1369.) He explained the basis for his conclusion:

> Inanimate objects are sometimes parties in litigation. A ship has a legal person-

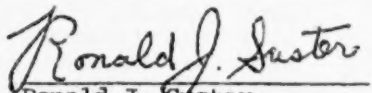
> ality, a fiction found useful for maritime purposes. The corporation sole--a creature of ecclesiastical law--is an acceptable adversary and large fortunes ride on its cases. The ordinary corporation is a "person" for purposes of the adjudicatory processes, whether it represents proprietary, spiritual, aesthetic, or charitable causes.
>
> So it should be as respects valleys, alpine meadows, rivers, lakes, estuaries, beaches, ridges, groves of trees, swampland, or even air that feels the destructive pressures of modern technology and modern life. (405 U.S. at 742-3, 92 S.Ct. at 1370.)

Surely if ecology and concern about the environment can lead us to consider bestowing standing upon both geographical features and vegetation, how much more should we be moved by modern science and medical advances to insure legal awareness and protection for alpha, that intrauterine occupant and traveler which each of us once were.

CONCLUSION

This Court should consider the interests of the alpha in reviewing abortion legislation.

Respectfully submitted,



Ronald J. Suster
Attorney at Law
LAWYERS FOR LIFE
655 Broadway Avenue
Cleveland, Ohio 44146
Tele: 216-232-5765
Attorney for Amicus Curiae

Of Counsel:
Mary Ann Johanek
Joseph Meissner
Earl Krock
Thomas Kondzer
Dan Murray
Art Foth

Legal Assistant:
James Crawford

APPENDIX 1: Chapter 20 excerpted from Aborting America by Dr. Bernard Nathanson, with Richard N. Ostling (New York: Doubleday & Company, Inc., 1979; from edition published by Life Cycle Books, Toronto, Ontario, Canada)

SIGNALS FROM INNER SPACE

With these meretricious arguments behind us, we now turn to what abortion is really all about: What do we know about alpha, and how do we weigh its value and its claims over and against the mother's interests? Is this "human life," for instance? Human it unquestionably is, since it is organically part of the human species. "Life" also fits is we follow the common dictionary meaning (in this case, the *Random House*, unabridged): that state "manifested by growth through metabolism, reproduction and the power of adaption to environment through changes originated internally." Some anti-abortionists speak of "potential human life" as a sort of fall-back position, but I have never cared for this idea. We ought to examine actual data, rather than future potential, in coming to a decision.

To state that alpha is biologically "human life" of a certain sort does not answer our question. We must know what this means in biological detail. The following discussion only summarizes a vast and complex field of research, but I trust that it will cover the major points bearing on abortion. As techniques become more sophisticated, we will be picking up data earlier and earlier in alpha's existence, so these should be viewed as the "latest possible" point in alpha's development when things occur or become visible, under present knowledge.

A preliminary word about how the length of pregnancy is expressed. A pregnant woman talks about how many "months pregnant" she is. The obstetrician speaks of "weeks of pregnancy"; the "obstetrical weeks" are calculated from the first day of the last menstrual period, hence the synonym "menstrual weeks." However, in study of the developing human embryo the embryologist begins counting about two weeks later at ovulation or "conception," the fertilization of the egg. He typically talks of "days," but with embryological "weeks," two weeks must be added to translate each stage into "menstrual weeks." Confusingly, both embryologists and obstetricians speak of "weeks of gestation."

One of the most important new techniques for the study of alpha is ultrasonography, first described in 1958, which now does much of the work that the more hazardous X rays once performed. High-frequency sound waves are transmitted through the pregnant woman's abdomen, and the echoes are plotted to produce a visual image of alpha. Currently, the body of alpha within the amniotic sac can be seen at around six (obstetrical) weeks. Ultrasound provides an exact way to diagnose the existence of pregnancy and to determine the numbers of weeks of pregnancy. A major extension of the technique came in 1967 with the first report on realtime scanning, which transmits continuous impulses that are decoded to produce a moving image of alpha on a TV screen. The bedside console commonly in use today looks like one of those battery-operated portable TV sets that campers and boaters purchase. Research laboratories have more refined equipment. Realtime scanning allows us to study motor activity in the uterus, not only alpha's movement of arms and legs, but the pulsation of its heart and the movements of respiration. Another advance came in 1974: gray-scaling, which provides a more detailed depiction of alpha's body on the screen by more complex sonic emissions.

Another promising new technique is fetoscopy, a term that was established in 1974 following the first concentrated research in the early '70s. As with ultrasonography, it is applied both to establish the existence of defects (biochemical as well as physical) that might lead the mother to choose abortion, and also as a tool for diagnosis of alpha

as the patient, to help it survive. In fetoscopy, alpha is seen directly by use of a fiberoptic endoscope thrust into the pregnant uterus through the woman's abdomen. The best images for visual examination in early pregnancy are obtained at sixteen weeks, according to research done on 211 alphas at Toronto General Hospital during 1973-77.

Amniocentesis, now well known to women, is a procedure in which amniotic fluid is withdrawn in order to grow a culture for diagnostic analysis from cells that have flaked off of alpha's body into the fluid. Fetoscopy offers an improvement on this, in that healthy living cells can be plucked directly from alpha's scalp with a tiny forceps. With these specimens, study is quicker and more exact. With the aid of ultrasonography to guide the instrument, doctors are also able to obtain blood samples directly from alpha at eighteen to twenty weeks of gestation for diagnosis of specific diseases or of general health and nutrition. In one 1977 case, tissue was taken from alpha to establish the identity of the father in a disputed rape charge. We are now able to do blood transfusions on alphas inside the uterus from twenty-two weeks on. Injections and direct therapy for such blood problems as hemolytic anemia are near and "intrauterine fetal surgery may become a reality within a few years," according to Jordan M. Phillips of the University of California College of Medicine at Irvine. Clearly, the technique needs refining, for there is a "complication" rate of 5 per cent to 10 per cent with fetoscopy, but it holds great promise. Because of this rate, fetoscopy is not used presently except on a clinical research basis where there is a strong therapeutic need.

Even without these new perinatal procedures, the basics of alpha's bodily form and function were well-known to human embryology at the time the U.S. Supreme Court issued its 1973 rulings, even though the rulings made no use of them. The data were detailed in a friend-of-the-court brief filed by a large group of anti-abortion physicians, and also in the main brief of the State of Texas, which sought to uphold its anti-abortion law. The same material is available in a number of books, including an excellent volume that is readily understood by non-specialists: *From Conception to Birth: The Drama of Life's Beginnings* (Harper & Row, 1971) by the late Roberts Rugh and Landrum B. Shettles.

The life processes begin at fertilization, when the sperm unites with the egg to create a unique genetic entity for each alpha that will never be repeated. After fertilization the growing cell cluster spends about three days in the Fallopian tube and three days in the uterine cavity before it begins burrowing into the wall of the uterus. The burrowing is called implantation.

Even before this, the cells start to organize themselves ("differentiation") as they multiply rapidly, and all the familiar bodily sytems and organs appear in subsequent weeks. Some highlights:

THE CARDIOVASCULAR SYSTEM

At day 14 after conception, occasional heart contractions can be perceived, at day 17 blood cells begin to develop, and by day 18, alpha's primitive heart has been known to begin its work. A better breaking point, however, is day 24, in the fourth week, when in each alpha the embryonic heart (then a simple tube) has started irregular pulsation. The heartbeat soon gains in force and regularity. In the old medicine, a patient was pronounced dead when both breathing and the heartbeat ceased, and if we apply this rule within the uterus, this would be the apparent point when alpha's "life" would be said to exist.

By approximately day 31 the heart has settled into rhythmic contractions, and the second heart valve has appeared (or will over the next few days). By five and a half weeks alpha's heartbeat has a general configuration similar to that of an adult and is sometimes traceable by electrocardiogram (EKG). Alpha by now is also pumping its manufactured blood through its own closed vascular system. In the sixth and seventh weeks the EKG shows all the typical heart phases that are recorded in an adult. It is at this stage that the beating of the heart also becomes visible through real-time scanning. Alpha how has a functionally complete cardiac system, readily observed by the doctor—before many women even seek tests to find out whether they are pregnant.

THE NERVOUS SYSTEM

With the development of artificial life-sustaining machines, an *ad hoc* committee at the Harvard Medical School proposed in 1968 a new definition of death to supplant the old heart-lung rule. The "Harvard Criteria," now widely accepted, are based upon a total lack of brain function. In my "Deeper into Abortion" article, I proposed these as an appropriate way to define the parameters of "life" at the other end of existence, within the uterus. There are four negative criteria in the Harvard test, each of which is required in order to establish death: no response to external stimuli (e.g., pain), no spontaneous movements or respiratory efforts, no deep reflexes, and no brain activity as indicated by a flat electroencephalogramm (EEG.)

The traditional medicine had it that there was no cerebral electrical potential in alpha through most of the nine months of gestation. This was discredited by 1951, the earliest study of which I am aware, by two researchers at Japan's Hokkaido University who did EEG tests on sixteen aborted alphas that ranged from three to seven months. They found electrical activity open to detailed graphing in the brains of the two three-month specimens (weighing only 26 grams and 38 grams), with fine waves superimposed on irregular slow waves. The four-month specimens showed a brainwave reaction to sleep-inducing and stimulant drugs that was almost the same as that in the adult. The researchers concluded that alpha's brain cells possess an ability to control states of consciousness from an early stage.

In the United States, EEG work received little attention until the studies of Bernstine and Borkowski in 1955, 1956, and 1959, which showed EEG tracings beginning at 43 to 45 days. They found that in these earliest graphs, alpha's sleep spindles were not unlike those during the sleep of adults, and later in pregnancy the response to sedatives, stimulants, and oxygen deprivation shown by EEG activity was also similar to that in the adult. In a 1964 paper read at the A.M.A. convention, Hannibal Hamlin of Massachusetts General Hospital applied EEG findings on alpha to the Harvard Criteria for death and stated: "At an early prenatal stage of life, the EEG reflects a distinctly individual pattern that soon becomes truly personalized." EEG research in utero became far more precise in 1969 with the development of

new and more sensitive electrodes. Because the line of birth has been made so important by the Supreme Court rulings, I should also mention the work of Lawrence Chik *et al.* at the Perinatal Clinical Research Center, Case Western Reserve University, showing that EEG activity in alpha's brain does not change abruptly at the time that birth occurs.

Turning to embryology, the ectoderm (the cells that will become the basis of alpha's nervous system) arises during implantation, and the system itself starts to form at day 18, which is why days 18—28 are termed the "neurula stage." By day 20 the foundations of the central nervous system, including brain and spinal cord, are established. By day 30, three parts of the brain are present, and the eyes, ears, and nasal organs begin to form. On day 31 the nerve root fibers in the primal spinal cord are visible and, on day 33, so is the differentiation of the cerebral cortex, the section of the brain that governs higher and more sophisticated activity.

By the sixth week, the five primary regions found in the adult brain are evident. As early as day 36, movements have been recorded on film, which means the primordial nervous system is stimulating the muscles. The earliest reflex arcs are established at day 42. Alpha's brain waves have been traced by EEG, as noted, as early as 43 days and are always readily discernible by the eighth week. In week 6 or 7 alpha responds to touch. Clearly, then, the parallel to the Harvard Criteria would establish the existence of alpha's life by the sixth week of gestation. Some sensory details from this period: At day 39 nerve fibers connect with the olfactory lobe of the brain, laying the basis for the sense of smell. In alpha's eyes, the nerve cells of the retina form at day 44, and nervous pathways connect the retina with the brain at day 48, though we do not know then alpha first "sees."

The Harvard Criteria may be established early, but the "consciousness" claimed by certain researchers is more difficult to evaluate. Some writers think that alpha's EEG waves have a low amplitude and a radomness that suggest rather low sensory imput. With present technology, we cannot say when "consciousness" occurs, but this is such a fluid term that it may defy exact biological definition. However, the attribute that *is* open to scientific study is the motions of alpha's body, which relate also to the brain's activity. It is not known exactly when the brain controls

bodily movements. Early twitching could be caused by reflex arcs before the brain is in command. The brain surely controls more fluid motions.

The layman's mental image of alpha is that of a curled-up body that looks inanimate—the "fetal position." The modern obstetrician, through realtime scanning, thinks of alpha as an active entity, reaching out, raising its head, scratching its nose, and engaging in many other patterns with an altogether lively look. In an extensive monograph in 1976, Reinhold (of Vienna) stated that the first motions—slight changes of position—can be seen by realtime scanning around the eighth (menstrual) week, but motions are insignificant till 10—11 weeks when they become increasingly prominent and extensive. Then Birnholz *et al.* at Stanford University reported motions "from early in the first trimester" with considerable twitching of the trunk and head beginning as early as 7 weeks, independent limb movements by 8—10 weeks, and more elaborate motions subsequently. My colleague, radiologist Samuel Madell, tells me that alpha's motions are visible even earlier, at the first stages at which current ultrasonography is able to pick up alpha.

By the twelfth embryological week, when brain structure is essentially complete, alpha is spontaneously able to kick its legs, turn its feet, curl and fan its toes, move its thumbs, make a fist, bend its wrists, turn its head, squint, frown, open its mouth, suck its thumb, swallow amniotic fluid, and make inhaling-exhaling motions (though air, of course, is not inhaled until birth).

SEXUAL IDENTITY

With the modern emphasis on sexuality in defining personhood, it might to worth mentioning this aspect. The sex of alpha is fixed at fertilization. By day 14, it can be verified immunologically by the researcher by testing for the H-Y (male differentiation) antigen on the surface of alpha's cells.

Alpha produces its own primitive germ (sperm and egg) cells at day 21, after which they migrate within the developing body. By day 38 they cease migrating and are located in the forming testes and ovaries; these germ cells will become fully mature at puberty. At day 42 the penis begins to form in the male alpha; the female sexual organs form later. By day 46 the gonads have differentiated to the extent that sex could be determined by microscopic examination if it were not already knowable through biochemistry. At this time the 600,000 potential ova of a lifetime already exist in the female alpha.

OTHER BODILY FEATURES

To serious researchers on the definition of "life" or "death," the important thing is not anatomy, the fact that the heart or leg is there, but the activity of the heart or leg and how it initiates or responds to stimuli. Nonetheless, the following highly selective list of bodily features will indicate how remarkably early the differentiation of cells and systems can be seen, even by today's crude technology, and how bodily structure neatly accompanies and complements the heart and brain developments.

Week 2—At day 11 to 13 the primitive streak appears; it marks the main axis of what will be the body.

Week 4—By day 28 there are building blocks for 40 pairs of muscles from the skull through the developing spinal column. The mouth is opened and lung buds and a recognizable liver are visible. By the end of the week (with the body a mere ¼-inch long) intricately organized cell groups are differentiated into the incipient muscular, circulatory, digestive, and skeletal systems.

Week 5—By now, if not earlier, the stomach, esophagus, and intestines are defined. Arms and legs appear. The face begins to "look human," which is why this is the earliest point at which embryologists apply the designation "fetus" to alpha.

Week 6—Here fingers and limb muscles begin. By the end of the week the primitive skeletal system is complete. At 6 weeks or so, the major organ systems have formed.

Week 7—Digestive juices are present in a developed stomach, all fingers exist (though not in final form), individualized patterns are visible in the ears of various alphas, transitional kidneys are extracting waste, and cartilage is changing into bone.

Danforth's *Obstetrics and Gynecology* (3d ed., 1976) defines differentiation as ending when all structures exist that are destined to be present at birth and fixed this at week 11 with the appearance of the nutrient artery of the long bone in the arm. By week 12, the close of the so-called "first trimester," alpha is a fully developed, functioning human body in merest miniature, 3 inches in length and tipping the scales at ½ ounce. Its fingerprints and sole and palm lines are now unique for each individual and remain for permanent identification throughout life. (The palm lines come first, appearing in individualized patterns in week 8.) Facial expressions are now also individualized.

What remains? The mother will experience movements of the body within her ("quickening") at 16—17 obstetrical weeks, but we know from modern biology that this age-old rule of thumb for life's existence is meaningless. Alpha's movements actually begin many weeks earlier. The major bodily developments yet to come are the extraction of oxygen from the air by the lungs (breathing) and the body taking nourishment and eliminating waste other than through the umbilical cord, along with changed routing of blood in the circulatory system. These steps occur at birth, approximately 266 days after conception or 280 days from the last period. That is, unless nature—or man—forces birth to occur earlier.

BIOCHEMISTRY

The most productive avenue through which we are currently increasing our knowledge of alpha is the study of its complicated physiochemical processes. Past discussions of alpha's "humanity" have emphasized its genetic makeup or bodily development, but this is where the riddle may be solved.

Recalling the dictionary definition of "life," it is from biochemistry that we know that alpha from its earliest stage is a responding and initiating entity, not simply "part of the mother's body," as the pro-abortion phrase goes. Daniel

Callahan summarizes the facts succinctly: "Genetically, hormonally and in all organic respects save the source of its nourishment, a fetus and even an embryo is separate from the woman."

Alpha's biochemical biography begins with implantation. The group of cells that will become the placenta produces hormones that enter the mother's bloodstream and prevent menstruation, now and throughout pregnancy. Otherwise, no life can develop and alpha will "miscarry" and be washed away into oblivion. It is absolutely the case that the great bulk of developments from implantation and beyond are initiated by alpha. It is thought that even the impetus for the start of labor comes from alpha when it is ready to leave the womb.

The mother is not aware of it, but her body fights against the "invasion" at implantation. It mounts an immune attack because of the different antigenic makeup of the two organisms, mother and alpha. The mother's body instinctively recognizes alpha as a foreign object to be repulsed, just as it does when an alien kidney is transplanted. Alpha thus is clearly—biochemically—an "other," distinct and immunologically different. Immune systems are exquisitely complex, individualized, and antagonistic to each other; in tissue transplant work, one must go through dozens of matchings to find a feasible "fit."

Biochemistry is the major way in which the obstetrician determines that alpha exists, by searching for the "pregnancy hormone" HCG (human chorionic gonadotropin). Beginning decades ago, pregnancy could be confirmed this way by eight menstrual weeks. In the old "A-Z" test, the mothers urine was injected in mice or other animals, which were then dissected to find signs of ovulation under the influence of the hormone from the urine. After I entered obstetrics, the animal tests were superseded by immunological tests. The most reliable method today, one in growing use, is "blood serum radio-receptor assay," a very sensitive and sophisticated test for HCG. With this method, refined in 1973, we can pick up this telltale biochemical signal of pregnancy at the time of implantation, just nine days or so after fertilization, even before the start of the next menstrual period would be due.

Rather early on, alpha develops its own defined endocrine system. The pituitary gland, a most important controller of

biochemistry, begins functioning between (embryological) week 5 and week 7. For the first 20 weeks the pituitary gland apparently operates on its own; then it is tied into control from the brain. ACTH, the hormone from the pituitary gland that stimulates the adrenal gland, reaches levels that we are already able to measure between week 8 and week 12. Alpha's pancreas is defined by week 5 and functions through most of pregnancy.

It is increasingly clear not only that these biochemical processes are extremely complex, but that alpha's effect on the mother is far less understood than the reverse. There is much public attention to the impact of the mother's drug taking or cigarette smoking upon alpha; far less to alpha's biochemical impact on the mother. This opposite aspect may become of vital significance to obstetricians, and at the moment, we can only guess at the complexity of these hormonal processes. If we can break the code, alpha will have a million messages for us.

While the Supreme Court, altering historical protections, defines the concept of "person" in order to permit the elimination of alpha, we in science are continually widening the concept of life. In the far reaches of our past history, paleontology is looking for the line that marks the human community off from non-humanity by studying primordial remains, the true-to-life equivalent of novelist Vercors and his "tropis." We are able to discover what these beings looked like and what they did; this is where the definitions are fixed scientifically. We will never know with certainty what their "consciousness" was. Meanwhile, in the far reaches of space, radioastronomy is listening for bleeps from beyond in an anxious search for other humanoid beings "out there" that may be transmitting their codes to us.

If "back then" and "out there," why not listen "in here," inside the human womb? We must expand our definition, our search for humanity, and technology and science are forcing us to do this. As yet the general public is incompletely informed, but eventually the research wing of medicine will pull society along with it. With alpha it is just as if an intelligent race of beings is transmitting massive electrical impulses from a distant star, and we are not receiving them . . . or we are refusing to receive them.

CERTIFICATE OF SERVICE

I hereby certify that as required by the Supreme Court Rules copies of the foregoing Brief Amicus Curiae were mailed, by first class mail, postage prepaid, to the following on the 26th day of July, 1982. I further certify that all parties required to be served have been served, through their counsel of record:

Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115

Robert D. Pritt
Director of Law
City of Akron
166 South High Street
Akron, Ohio 44308

Robert A. Destro
Catholic League for Religious and Civil Rights
1100 West Wells Street
Milwaukee, Wisconsin 53233

Ronald J. Suster

Ronald J. Suster
Attorney at Law
LAWYERS FOR LIFE
655 Broadway Avenue
Cleveland, Ohio 44146

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1981

No. 81-746

CITY OF AKRON

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH

No. 81-1172
AKRON CENTER FOR REPRODUCTIVE HEALTH

v.

CITY OF AKRON

PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

AMICUS CURIAE BRIEF BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN

ALAN ERNEST
P.O. Box 2471
Washington, D.C. 20013
(703) 437-1178

Counsel for Amicus

CONTENTS

Interest of Amicus Curiae.....1

Summary of Argument.....2

Argument 3

I. ROE v WADE IS NO LAW AT ALL SINCE THE SUPREME COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS WHICH HAD BEEN DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT 3

II. ROE v WADE IS BASED ON FALSE EVIDENCE, AND THE VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE U.S. CONSTITUTION 14

III. THE U.S. SUPREME COURT HAS WILLFULLY USED UNCONSTITUTIONAL PROCEDURES TO MAINTAIN THE ROE v WADE KILLINGS ...24

IV. THE U.S. SUPREME COURT HAS CONFESSED IN COURT TO GUILT OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE 27

Conclusion..... 33

AUTHORITIES

Cases:

Baxter v Palmigiano, 425 U.S. 308 28

Clarke v State, 117 Ala. 1 10

Cohen v Virginia, 6 Wheat. 264 16

Commonwealth v Harmon, 4 Barr. 269..... 10

Dartmouth College v Woodward, 4 Wheat. 518 ... 15,21

Gagnon v Scarpelli, 411 U.S. 778 26

Goldberg v Kelly, 397 U.S. 254..... 26

Gulf, Colo. & S.Fe RR v Ellis, 165 U.S. 150 23

Imbler v Pachtman, 424 U.S. 409 26

In Re Gault, 387 U.S. 1 26

Marbury v Madison, 1 Cranch 137 30

Morrissey v Brewer, 408 U.S. 471 26

People v Chavez, 77 Cal. App. 2d 621..... 10

Regina v Trilloe, 174 Eng. Rep. 674 5

Regina v West, 2 C & K 784 5,6

Rex v Senior, 1 Moody CC 346 5

Ross v Oregon, 227 U.S. 150 10,32

Santa Clara v. So. Pac. RR, 118 U.S. 394..... 23

State v Moore, 25 Iowa 128 20

State v Winthrop, 43 Iowa 519.....7

Sturges v Crowninshield, 4 Wheat. 122..... 15,21

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3 Trials of War Criminals Before the
Nuernberg Military Tribunals (1951)..... 26,29

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Procedure, Pleading and Evidence (1860).....6,20

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Wigmore, Evidence (Chadborn Rev. 1972)..... 28

U.S. Constitution:

Fourteenth Amendment- "Any Person".....3-13,14-23

Fifth and Fourteenth Amendments- Due Process..... 24

In The
SUPREME COURT OF THE UNITED STATES
October Term 1981

No. 81-746

CITY OF AKRON

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH

No. 81-1172

AKRON CENTER FOR REPRODUCTIVE HEALTH

v.

CITY OF AKRON

AMICUS CURIAE BRIEF BY THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN IN SUPPORT OF THE CITY OF AKRON

Interest of Amicus Curiae

The Legal Defense Fund For Unborn Children is an organization whose purpose is to protect the constitutional rights of children unborn and born alive. The parties have not done this. The amicus submits facts, authorities, and arguments, not submitted by the parties, which dispose of all the issues raised by the parties.

Summary of Argument

Roe v Wade, 410 U.S. 113, is a mistake of law. It is no law at all.

In Roe v Wade, the U.S. Supreme Court Hitler-like asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment.

Moreover, the Court's conclusion in Roe v. Wade, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's evidence are fabricated and false.

The U.S. Supreme Court has already admitted that Roe v Wade is a mistake of law, and this is the legal equivalent of the express overruling of Roe v Wade. Roe v Wade should now be expressly overruled to reflect the true status of the law.

ARGUMENT

ROE v WADE IS NO LAW AT ALL, SINCE THE COURT HITLER-LIKE ASSERTED TO LEGALIZE KILLINGS DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT

Counsel presents new evidence herein,[1/] not presented by the parties, to show that many of the killings that the Supreme Court asser-

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1./ The new evidence was published in The Washington Post on September 12, 1979, under the caption "WASHINGTON LAWYER CHARGES U.S. SUPREME COURT WITH MASS MURDER," as set out below. That the charging evidence can be published in the dominant newspaper in the nation's capital, but, as the victims are being killed, the evidence can not even be heard in this Court, proves the complete criminal degeneracy of the judicial system. The newly discovered evidence shows the Court asserted to legalize killings defined as murder since before the adoption of the 14th Amendment.

SUMMARY OF ARGUMENT

MANY ROE v WADE KILLINGS ARE MURDER

The evidence shows that many of the killings permitted by Roe v Wade, 410 US 113(1973) were murder in 1868. Since the killings were murder in 1868, then absent a constitutional amendment, the killings are still murder, and Roe v Wade is not law at all.

ARGUMENT

1. Introduction to Evidence

The evidence presented herein shows that, at the time the Fourteenth Amendment was adopted in 1868, the unlawful killing, with malice aforethought, of a child born alive was murder. Killings of children born alive were not treated as a special category, as was abortion.

It is thus absolutely indispensable to examine what "born alive" meant in 1868. It is obvious that, if the life of a child born alive was protected by

ted to legalize in Roe v Wade, 410 US 113, had thereto been defined as murder. It is just as if the Court asserted a right to kill Jews. Obviously, absent a constitutional amendment, these killings are still murder. Justices who have presumed to permit these killings may now be facing the death penalty in very many states.

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the murder laws in 1868, then it is a person within the language and meaning of the Fourteenth Amendment.

The evidence shows that in 1868, born alive did not mean natural birth after nine full months of gestation; nor did it mean birth after viability, "that is, potentially able to live outside the mother's womb, albeit with artificial aid." Roe v Wade, 410 US at 160. If abortion resulted in a live but unviable child that died as a consequence of its not being able to survive outside the womb, it was murder and punishable by the death penalty.

The evidence shows that the hysterotomy is a common method of performing abortions under Roe v Wade. This is essentially a Caesarean in which a live but unviable child is removed from the womb and left to die. The legal authorities show that in 1868, such a killing was murder, and punishable by the death sentence.

In summary, what was murder in 1868, can not now be decreed a constitutional right. Without an amendment to the Constitution, the killings must still be murder, and the Justices who permitted these killings may be guilty of mass murder in the first degree. This is still punishable by the death sentence in many states.

Many people would no doubt be astonished to learn that the case presented herein for the unborn is the very case they would have to present for themselves if their right to life were challenged. For example, take almost any group of persons, such as the insane, invalids, Jews or Catholics. Suppose it were claimed in federal court that the

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2. The English Law

The English law, as reflected in the writings of Coke(3 Inst. 50), Hawkins(1 Hawkins Ch. 13, s. 16) and Blackstone(4 Bl. Com. 198) defined the felonious killing of a child "born alive" as murder, even if the child received the fatal wound in the womb.

These authorities were followed by the English courts in permitting prosecutions of the killings of children born alive as murder. Rex v Senior, 1 Moody CC 346 (1832); Reg. v Trilloe, 174 Eng. Rep. 674 (1842); Reg. v West, 2 C & K 784 (1848).

Most critically, in the English law, a child did not have to be viable to be born alive. In 1848, the leading case of Regina v West, 2 C & K 784, was decided. The indictment for murder alleged that the defendant had inserted a "certain pin" "upward into the womb " of a pregnant woman for the purpose of producing the abortion of a "quick" child; and that this resulted in the child being "prematurely born and brought forth alive from and out of the womb." Id., 784-85. The child died shortly thereafter. A "medical witness" had testified that:

"(I)t was a healthy child; but that, being born at that period of gestation, it was impossible that it could live any considerable length of time separated from the womb of the mother. It was incapable

right of "privacy" announced in Roe v Wade includes the right to kill members of these groups, as well as the unborn. If the burden were suddenly thrust on these groups, as it was thrust on the unborn, to prove that they are persons whose lives are protected by the Fourteenth Amendment, what factual, non-argumentative evidence could they find to estab-

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of maintaining a separate and independent existence." Id., at 786.

The judge, relying on Coke and Blackstone, instructed the jury:

"The prisoner is charged with murder; and the means stated are, that the prisoner caused the premature delivery of the witness, Hensen, by using some instrument for the purpose of procuring abortion; and that the child so prematurely born was, in consequence of its premature birth, so weak that it died. .... I am of opinion(and I direct you in point of law), that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies in consequence of its exposure to the external world, the person who by her misconduct so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder." Id., at 788.

The case of Regina v West, supra, was presented by the leading English writers as the correct statement of the law of murder. See, e.g., 1 J.F. Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence 783 (Waterman Am. ed. 7th ed. 1860); 1 W.O. Russell, A Treatise on Crimes and Misdemeanors 671-672 (4th ed. 1865); A.S. Taylor, A

lish their right to life?

As the case of the unborn shows, it would do no good to object that no one ever heard of such a constitutional right to kill, or to object that such killings had thereto been defined as criminal. And the Fourteenth Amendment merely states that it pro-

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Manual of Medical Jurisprudence 516(Penrose Am. ed. 6th ed. 1866). Consequently, the abortion of a quick but unviable child that resulted in the child being born alive so prematurely that its death was caused by its inability to survive outside the womb, was murder.

3. The American Law Of Murder in 1868.

The English common law of murder of children born alive is significant since American courts used the English common law to construe their murder statutes. Clarke v State, 117 Ala. 1(1898); Hamilton v United States, 26 App. D.C. 382(1905).

American courts cited Coke, Hawkins, Blackstone, and the English court decisions, as authoritative definitions on the law of homicide of children born alive. See, e.g., Clarke v. State, 117 Ala. 1(1898); State v Winthrop, 43 Iowa 519(1876). By 1868, leading American legal authorities had specifically cited Regina v West, supra, as the correct law of murder of a child born alive. (As already noted, that case held that if a criminal abortion resulted in the premature delivery of a quick but unviable child that died after delivery as a consequence of its being so prematurely delivered that it could not survive outside the womb, it was murder.) See, e.g., F. Wharton, A Treatise on the Law of Homicide in the United States 96-97(1855). By 1868, this appears to be the uncontradicted view.

tects life of "any person." So, as with the unborn, the Amendment does not expressly refer to the insane, or invalids, or Jews, or Catholics; and its legislative history does not appear to specifically refer to any of these groups. As with the unborn, the murder laws do not expressly refer to the insane,

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Consequently, the evidence shows that the life of a quick but unviable child born alive was protected by the murder laws in 1868.

4. The Law Of Murder In 1868 And The Fourteenth Amendment

Since the evidence shows that the life of a quick but unviable child was protected by the murder laws in 1868, the evidence likewise establishes that the child so born alive is a person within the language and meaning of the Fourteenth Amendment.

By seizing upon viability, Roe v Wade permits the killings of quick but unviable children born alive. The Supreme Court presumed to decree the killings of these children to be a constitutional right without any examination whatever to see if these children were persons within the language and meaning of the Fourteenth Amendment. It is a naked decree without any investigation into the law of murder of children born alive.

This raises the question,- Does the Supreme Court have the Hitler-like power to decree murder to be a constitutional right? If invalids were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill invalids? If Jews were protected by the murder laws in 1868, can the Supreme Court decree, without evidence or investigation, a constitutional

or invalids, or Jews, or Catholics; and their legislative histories, to the extent they have any, do not appear to specifically refer to any of these groups. The principle in the Declaration of Independence, that all people are "created" equal and endowed with an unalienable right to "life," having been

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right to kill Jews? If newspaper editors were protected by the murder laws in 1868, can the Supreme Court, without evidence or investigation, decree a constitutional right to kill newspaper editors?

No doubt the Supreme Court bears the burden of proving, by evidence so conclusive that it will not admit of a rational doubt, that it possesses the power to decree murder to be a constitutional right.

5. The Hysterotomy Abortion Under Roe v Wade

A common way to perform abortions under Roe v Wade is by hysterotomy. See, Commonwealth v. Edelin, 359 NE 2d 4(Mass. 1976). A hysterotomy is essentially a Caesarean, in which a live but unviable child is removed from the womb and left to die. 1 Hearings Before the Subcommittee On Civil And Constitutional Rights Of the Committee of the Judiciary, House of Representatives On Proposed Constitutional Amendments on Abortion 397 (94th Cong., 2nd Sess. 1976).

As established by medical testimony during the 1976 House Abortion Hearings, "With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry .... Almost all were born alive." Id., at 397.

Consequently, by definition, in 1868, these hysterotomy abortions could have been prosecuted as murder.

sneered out of court in the unborn's case, now provides no assurance for anyone. So what factual, non-argumentative evidence is there for members of these groups to protect themselves from extermination?

The case presented herein for the unborn,

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6. Roe v Wade and Mistake of Law

The Supreme Court itself has recognized that constitutional provisions against ex post facto laws do not apply to judicial decisions that are a mistake of law. Ross v Oregon, 227 US 150(1913). Consequently, if Roe v Wade is a mistake of law, then mass murder is being perpetrated in America. The Roe v Wade hysterotomy killings, by definition under the common law, and thus constitutional law, violate the positive criminal murder statutes throughout the United States.

The killings of children born alive have been prosecuted as murder in the first degree, Comm. v Harmon, 4 Barr. 269 (Pa. 1846)(child thrown in creek); or murder in the second degree, Clarke v State, 117 Ala. 1 (1898)(wife beaten, child die from injuries); or manslaughter, People v Chavez, 77 Cal. App. 2d 621(1947)(child neglected),- according to the facts of the particular case, as in any other homicide.

In connection with these judicial killings, it is relevant to note that the Supreme Court decreed murder to be a constitutional right without any examination whatever of the law of murder of children born alive. And as Abraham Lincoln noted, "(I)t is an established maxim in morals that he who makes an assertion without knowing whether it is true or false, is guilty of falsehood; and the accidental truth of the assertion, does not justify or excuse him." 1 The Collected Works of Abraham Lincoln 384 (Basler ed. 1953). Since Lincoln's day, this "maxim in morals"

supra note 1, is thus the case for everyone else. The common law is the dictionary; it has traditionally been used to define the terms of the homicide statutes. It is this same body of factual evidence upon which all groups must ultimately rely to establish

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has also been a textbook definition of perjury. See, 3 Wharton's Criminal Law and Procedure, § 1308, p. 673 (12th ed. 1957).

Consequently, rational people are entitled to believe, and a jury may be permitted to find, that the process by which the Supreme Court decreed murder to be a constitutional right is perjury or criminal fraud. It seems reasonable that such judicial killings, after such prolonged deliberation and adherence, could be prosecuted as murder in the first degree. Many states still punish mass murder in the first degree with the death sentence.

It may be that the judges responsible for the judicial killings did not believe that they were breaking the law. But, as Justice Oliver Wendell Holmes once wrote, "Ignorance of the law is no excuse for breaking it." "It is no doubt true that there are many cases in which the criminal could not have known that he was breaking the law, but ... the lawmaker has determined to make men know and obey." Holmes, The Common Law 41 (Howe ed. paperback 1963).

It now full well appears that the Justices of the Supreme Court of the United States have presumed to decree murder to be a constitutional right, without any evidence or examination whatsoever, with the death penalty the possible consequence of their decision being a mistake of law.

It now appears that, unless the Supreme Court can prove by evidence, beyond a doubt based on reason, that it has the Hitler-like power to decree mass

their right to life. The evidence, supra n.1, conclusively proves that the Supreme Court has Hitler-like, that is, by naked decree without any investigation of the law of murder, asserted to legalize mass murder. Roe v Wade is a mistake of law, that is, no law at all. All the countless thousands of

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murder to be a constitutional right, then Roe v Wade is just such a mistake of law.

CONCLUSION

Is government of laws founded upon evidence, or the mere naked decrees of men holding office for life?

The evidence proffered herein would appear sufficient to permit reasonable people to conclude beyond a reasonable doubt that the Supreme Court of the United States has committed mass murder in the first degree. The evidence would appear sufficient for reasonable people to conclude that, upon a scale never seen before in the peacetime history of the world, "The dagger of the assassin was concealed beneath the robe of the jurist." The Justice Case, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 985 (GPO 1951).

If the United States were being ruled over by a Tribunal of Murderers, holding office for life, nakedly decreeing mass murder to be a constitutional right, in open defiance of the evidence, and presuming to be blindly obeyed by all courts, executives, legislatures, and people whatever without question, regardless of the evidence, then surely it would be the most astounding event in the legal history of the human race.

of Roe v Wade "born alive" killings since 1973 can be prosecuted as murder. The Court can look in the face of one of the victims it has killed. 2/

The evidence shows that the United States is being ruled over by a tribunal of murderers, which has Hitler-like asserted to legalize mass murder, and maintains the killings by refusing to allow truth to work in Court. But even the U.S. Supreme Court is not above the law of murder. The Justices responsible for these killings may be facing the death penalty in very many states.

Even a party, who argues in court that the killings can continue without question, can be prosecuted for murder. 3/

2./ Appendix A-1, infra. This was a second stage abortion induced by prostaglandin. Such abortions not uncommonly result in the child being born alive. Floyd v. Anders, 440 F. Supp 535, 538(1977).

The common methods of second stage abortions-hysterotomy, prostaglandin, and even salt poisoning-can result in children being born alive. Jeffries and Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981.

3./ Infra pages 27-32.

II.

ROE v WADE IS BASED ON FALSE EVIDENCE, AND THE VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE U.S. CONSTITUTION.

The evidence, summarized below, proves that the Court's conclusion in Roe v Wade, 410 U.S. 113, 158, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's evidence are fabricated and false. The evidence establishes, beyond the legal power of any federal judge to deny, that the unborn are persons whose lives are protected by the Fourteenth Amendment, as follows:

A.

Even the Court admitted in Roe v Wade, 410 U.S. at 156-157, that if the unborn were "a 'person' within the language and meaning of the Fourteenth Amendment," then the case for a constitutional right to kill the unborn, as claimed in Roe v Wade, "of course collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

B.

The terms of the Fourteenth Amendment ("nor shall any state deprive any person of life ... without due process of law")(emphasis added) are "universal in their application." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). The words "any person" admit of no exceptions whatever. Thus, on their face, the words "any person" include the unborn, as everyone else.

C.

The holdings of Chief Justice Marshall show that the Supreme Court had no lawful power to construe an exception to express, universal terms (such as "any person") unless the Court can show that "the absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[1/] And the Court must further prove that "had this particular case been suggested " to the framers, "the language would have been so varied as to exclude it."[2/]

1./ Sturges v Crowninshield, 4 Wheat. 122,202-3.
2./ Dartmouth College v Woodward, 4 Wheat.518,644-5.

Chief Justice Marshall founded the universality of the Supreme Court's jurisdiction on these very rules. 3/

The Court thus bore a very extraordinary evidentiary burden before it could create an exception to the universal terms "any person" so that victims could be killed in violation of positive criminal statutes. 4/

3./ Cohen v Virginia, 6 Wheat. 264, 378-380.

4./ The truth of this extraordinary evidentiary burden can be demonstrated by applying it to various cases. Before the Court could create an exception to the universal terms "any person" so that Jews, or Catholics, or the insane, could be killed like the unborn, the Court would have to demonstrate that "the absurdity and injustice of applying the provision [the terms- "any person"] to the case [the case of - Jews, Catholics, or the insane],would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application." Sturges v. Crowninshield, supra. And the Court must prove that if the case of the Jew, Catholic, or the insane had been suggested to the framers of the Fourteenth Amendment, then "the language would have been so varied, as to exclude it." Dartmouth College v. Woodward, supra. The framers would have changed the words of the Amendment to read that "No state shall deprive any person, except Jews, Catholics or the insane, of life ... without due process of law."

These same extraordinary evidentiary burdens must universally apply to all groups whose personhood may be challenged, including the unborn. Thus the Court bore the heaviest evidentiary burden possible in constitutional interpretation in order to create an exception to the universal terms "any person" so the unborn could be killed for any reason, or no reason, in violation of positive criminal statutes.

D.

The Supreme Court presented false evidence in Roe v Wade to support its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. And, but for the false evidence, there is not even a credible foundation, much less a compelling one, for denying the protection of the express, universal terms "any person" to the life of the unborn.5/

5./Summary of False Evidence:

In introduction, at the time the Fourteenth Amendment was adopted in 1868, most states had already enacted positive statutes that made abortion a crime unless it were necessary to save the life of the mother. Within a few years, these criminal abortion statutes were virtually universal.

Consequently, any theory of a constitutional right to abortion on demand faced an impossible contradiction: How is it possible that the people who adopted the Fourteenth Amendment had enacted positive criminal statutes to protect unborn life, but, at the same time, without a single word of explanation, intended to imply an exception to the express, universal terms that not "any person" can be deprived of life without due process of law, and to create a constitutional right to kill the unborn?

To resolve that fatal contradiction, the Court asserted the hypothesis that when the criminal abortion statutes were first enacted, the laws were not intended to protect unborn life, but rather were

only intended to protect the mother. This hypothesis was falsely fabricated and used as follows:

A.

The Supreme Court first asserted, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v Wade, 410 U.S. at 148. This was asserted as fact.

The only authority cited by the Supreme Court to prove this assertion of fact was a 20th century medical history book, Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v Wade, supra, at 148n.43. But this book merely described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The reference did not even mention the abortion operation.

However, the 19th century obstetric authorities throughout the Western world prove the Court's assertion of fact to be false. These 19th century obstetric authorities, based upon their own experience in performing abortions, and from hundreds of cases reported from around the world, declared in their obstetric textbooks that the abortion operation, the operation of artificially evacuating the fetus from the womb, was "perfectly safe" to the mother, 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802)(English physician); or "experience has proved that the dangers of the operation are reduced to a small matter," A.L.M. Velpeau, M.D., A Complete Treatise on Midwifery 530 (4th Am. ed. 1852)(French physician); or "to the mother there is very little danger." H.L. Hodge, M.D., The Principles and Practice of Obstetrics 293 (1864)(American physician). In short, the 19th century obstetric authorities prove the Supreme Court's assertion of fact to be false.

of proof and persuasion, as set out in the holdings of Chief Justice John Marshall. See page 15 , supra. Instead of the burden of

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The Supreme Court never revealed the "hazardous" abortion "procedure" to which it was referring. Actually, the 19th century physicians used the ancient method: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus" to "come on," which resulted in the expulsion of the fetus from the womb. 2 Denman, supra, 99. One 19th century physician traced this operation back almost 2000 years. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

Consequently, the 19th century physicians were using an ancient abortion operation which they described as not hazardous to the woman. The Supreme Court did not examine even one 19th century obstetric textbook. And the medical textbooks prove its assertion of fact, "When most criminal laws were first enacted, the procedure was a hazardous one for the woman," to be false.

B.

The Supreme Court next asserted, "Abortion mortality was high." Roe v Wade, 410 U.S. at 149. This is asserted as fact.

The Supreme Court asserted "Abortion mortality was high," without any authority to support it. It was a naked assertion. The 19th century obstetric authorities also prove this assertion of fact to be false. The medical authorities, supra, expressly asserted that the abortion operation was not deemed to be hazardous to the mother.

Consequently, the Court's assertion that "Abortion mortality was high" is false.

C.

Upon the two false assertions of fact, the Court falsely infers that"a State's real concern in enacting a criminal abortion law was to protect the

proving that including the unborn within the terms "any person" would "be so monstrous, that all mankind would, without hesitation, unite in rejecting the application," the

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pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v Wade, 410 U.S. at 149. Thus a false inference was drawn from false facts.

D.

From the false inference that the criminal abortion laws were not intended to protect the lives of the unborn, the Court falsely inferred that, likewise, the framers of the Fourteenth Amendment did not intend it to protect the lives of the unborn, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. This false conclusion is drawn from a false inference which is drawn from false facts.

Moreover, as independent corroboration of the purpose of the criminal abortion statutes to protect the unborn, 19th century authorities in criminal law, e.g., 2 Archbold, Archbold's Criminal Procedure, Pleading and Evidence 295 (6th ed. 1853); medical jurisprudence, e.g., F. Wharton and M. Stille, M.D., A Treatise on Medical Jurisprudence 339, 927(2d ed. 1860); medicine, e.g., 12 Transactions of the American Medical Association 27-28(1860); as well as state supreme courts, e.g., State v Moore, 25 Iowa 128, 131, 135-36(1868), leave no doubt that these 19th century abortion laws were intended to protect the lives of the unborn. Consequently there is no other body of evidence to come to the Court's rescue.

CONCLUSION

The Supreme Court bore the burden of demonstrating, beyond a doubt based on reason, that the absurdity and injustice of including the unborn within the

U.S. Supreme Court fatally reversed the burden. The Court placed the burden on the unborn to prove with "assurance" (that is, to make certain and put beyond doubt) that they were persons within the terms "any person," or the unborn would be excluded from the terms "any person." Rather the burden was on the Supreme Court to prove

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terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application," Sturges v Crowninshield, supra. And the Court had to prove to a demonstration that if the case of the unborn had been presented to the framers and adopters of the Fourteenth Amendment, "the language would have been so varied as to exclude it." Dartmouth College v Woodward, supra.

But, the Supreme Court did not cite even one single 19th century authority that expressly agreed with its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," much less one that asserted that there was a constitutional right to kill the unborn, as set out in Roe v Wade. And the court's assertion that the 19th century abortion laws were not intended to protect the lives of the unborn is shown to rest on false evidence.

The legal history demonstrates that the people who framed and adopted the Fourteenth Amendment not only intended it to protect the lives of the unborn, but these people had already enacted criminal abortion laws to do so in fact. This case for the unborn is absolutely conclusive. The terms "any person" must include the unborn.

with "assurance" that the unborn were not included within the terms "any person" or they would be included.[6/] And the evidence for the unborn is far stronger than that for many groups which the Court has judicially recognized to be included within the uni-

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6./ The Court illegally switched the burdens of proof and persuasion in the following manner. The Court first decreed a constitutional right to kill the unborn. Roe v Wade, 410 U.S. at 153. Incredibly, subsequently, the Court examined the question of the personhood of the unborn under the Fourteenth Amendment. Thus, in accordance with its compelling state interest test, once the constitutional right to kill the unborn was established, the burden was on the unborn to demonstrate the compelling justification of the criminal abortion statutes; that is, the burden was on the unborn to affirmatively prove that they were persons within the meaning of the terms "any person" in the Fourteenth Amendment- or be excluded.

Moreover, the objections which the Court raised to defeat the personhood of the unborn in Roe v Wade, 410 U.S. at 156-158 were either false, or irrelevant. This evidence will be submitted to the Court on request. The Court exactly perceived its function as that of a criminal defense lawyer who only has to raise doubts about the prosecution case to win. But the Court cannot exclude anyone from the protection of the words "any person" by merely working up quibbles or "inconsistencies." Roe v Wade, supra, 158 n.54.

Could the Court first decree a constitutional right to kill Jews? And then place the burden on the Jews to affirmatively prove that they are included within the terms "any person"? And then, by quibbling with the Jews' evidence, decide the Jews were not included within the terms "any person" so they could be hauled off to the graveyard?

versal terms "any person." 7/

The Supreme Court has exactly defied the express words "any person" in the Constitution, and their spirit, 8/ as well as the plain intention of the framers, 9/ and condemned to death those victims whom the Constitution endeavors to preserve.

7./ The Court was so certain that "corporations" were included within the terms "any person" that it forbade any oral argument to the contrary. Santa Clara v. So. Pac. RR, 118 U.S. 394,396. And the Court held that "strangers and aliens" were included within the terms "any person" by merely observing: "These terms are universal in their application." Yick Wo v Hopkins, supra, at 369.

8./ The uncontradicted scientific evidence in Roe v Wade showed that the unborn child "is alive," that the fetal heartbeat begins "pulsations at 24 days," and "brain waves have been noted at 43 days."

The Court itself has recognized that, while the Declaration of Independence is not law in itself, yet it is "the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of the Declaration of Independence." Gulf, Colo. & S.Fe v Ellis, 165 U.S. 150, 159-160.

The undisputed scientific evidence proves that the unborn child has been "created" and thus endowed with an "unalienable" right to "life," and within the spirit of the terms "any person." The Court would amend the Declaration to read that "all men are created equal-except those created to die for the convenience of others."

9./ The evidence, supra n.5, shows that the adopters of the 14th Amendment not only intended the lives of the unborn to be protected by the terms "any person," but they had already enacted criminal abortion statutes to do so in fact.

III.

THE U.S. SUPREME COURT HAS WILLFULLY USED UNCONSTITUTIONAL PROCEDURES TO EFFECT AND MAINTAIN THE ROE v WADE KILLINGS.

The Supreme Court willfully used unconstitutional procedures to effect the Roe v. Wade killings.[1/]

And the Supreme Court has subsequently decided many abortion cases on the merits, but willfully used unconstitutional procedures to maintain the killings, as follows:

1. The Supreme Court willfully refuses to

1./ Counsel did not especially represent the unborn in the District Courts in Roe v Wade and Doe v Bolton. And the Supreme Court denied Bolton's request to allow counsel to represent the unborn in the Supreme Court. Thus, counsel did not represent the unborn at any stage of the original proceedings.

The question of the personhood of the unborn under the Fourteenth Amendment came up for the first time in the original proceedings after the cases reached the Supreme Court. Since no group had ever been excluded from the protection of the Fourteenth Amendment so they could be killed, the original parties had no notice of the kind of evidence, or the burdens of proof and persuasion the Court would deem determinative. The first time the parties understood this was when Roe v Wade issued, and the victims were condemned to death. But the Court had taken judicial notice of numerous facts and factors which the original parties had not seen, much less cross-examined in a judicial proceedings. An original party asked permission to cross-examine the Court's evidence. But the Supreme Court would not allow its evidence to be cross-examined.

allow retained(no cost to taxpayers)counsel to represent the victims being killed; [2]

2. The Supreme Court willfully refuses to allow the evidence in Roe v Wade, which it used to condemn the victims to death, to be cross-examined; [3]

3. The Supreme Court willfully refuses to allow evidence to be presented on behalf of the victims being killed to establish their right to life under the U.S. Constitution.[4]

The U.S. Supreme Court's own rulings on due process of law show these procedures to

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2./ Some of these cases are: Colautti v Franklin, 58 L Ed 2d 596, motion to allow counsel represent unborn denied 57 L Ed 2d 1131(1978); Anders v Floyd, 59 L Ed 2d 442, motion to allow counsel represent unborn denied 58 L Ed 2d 235(1978); Bellotti v Baird, 61 L Ed 2d 797, motion to allow counsel represent unborn denied 59 L Ed 2d 29(1979); Ashcroft v Freiman, 59 L Ed 2d 630, motion to allow counsel to represent unborn denied 59 L Ed 2d 630(1979); United States v. Zbaraz, 65 L Ed 2d 831, motion to allow counsel represent unborn denied 62 L Ed 2d 665-6(1980); Harris v. McRae, 65 L Ed 2d 784, motion to allow counsel represent unborn denied 63 L Ed 2d 775(1980); H.L. v. Matheson, 67 L Ed 2d 388, motion to allow counsel represent unborn denied 64 L Ed 2d 234 (1980).

3./ Supra Note 2.

4./ Supra Note 2.

to be unconstitutional[5/] and criminal.[6/]

5./ The U.S. Supreme Court has held that even in civil, non-judicial proceedings, where crucial deprivations are threatened, such as loss of welfare, due process guarantees (1) Notice; (2) the right to be heard and to present evidence; (3) the right to confront and cross-examine adverse evidence; (4) the right of representation by retained counsel; (5) the right of an independent decisionmaker; (6) the right to have a written statement by the decisionmaker of the evidence relied upon and the reasons for the determination. Goldberg v Kelly, 397 U.S. 254, 268-271(1970). In Re Gault, 387 U.S. 1(1967); Morrissey v. Brewer, 408 U.S. 471 (1972); Gagnon v Scarpelli, 411 U.S. 778 (1973); Viteck v Jones, 63 L Ed 2d 552 (1980). Since the unborn are being killed, there can be no question whatever that these elements of due process of law are guaranteed.

6./ The criminality of such process is evident. Could a judge use such procedures to legalize the killings of the insane, or Jews? These are effectively the same procedures cited by the Nuremberg Court in convicting the Nazi judges of criminal extermination. United States v Altstoetter(The Justice Case), 3 Trials of War Criminal Before the Nuernberg Military Tribunals 1046(1951).

Can it now be argued that a judge, who could not condemn even one Jew to death without counsel in a criminal case, could condemn all Jews in the United States to death without counsel by calling it a civil case and decreeing that the lives of Jews were not protected by the Constitution? A person cannot be deprived of life or liberty without due process of law, regardless of the description of the proceeding. The Constitution thus guarantees that any proceeding to determine if one is a person within the meaning of the Constitution must satisfy due process of law.

And any judge who willfully deprives any victims of constitutional rights under a guise of law can be criminally prosecuted. Imbler v. Pachtman, 424 U.S. 409 (1976).

IV.

THE U.S. SUPREME COURT HAS CONFESSED IN COURT TO GUILT OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE V WADE, 410 U.S. 113 (1973).

For the 76th time, the U.S. Supreme Court is accused in its own Court with criminally exterminating millions of lives in violation of the U.S. Constitution, and 18 U.S.C. 242.[1/]

For the 52nd time, the U.S. Supreme Court is accused in its own court with mass murder in violation of State and federal statutes.[2/]

For about the 56th time, the U.S. Supreme Court is accused in its own Court with willfully using unconstitutional, criminal procedures to maintain the Roe v Wade killings.[3/]

But, year after year, the U.S. Supreme Court has not denied the charges, much less attempted to prove the charges to be false. Under this Court's own rulings, this silence year after year in the face of accusation, while the victims are being killed, amounts

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1./ Charges based on evidence, supra page 14.

2./ Charges based on evidence, supra page 3.

3./ Charges based on evidence, supra page 24.

to a confession in court that the charges are true.[4/]

Furthermore, the evidence presented herein makes it clear as daylight why the Supreme Court is silent in the face of the charges. The evidence establishes, beyond the legal power of any federal judge to deny, that the charges are true. Thus, this ancient law of

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4./ Under "the tacit confession rule," McCormick on Evidence §§ 161, 270, failure to deny a charge is equivalent to a confession that the charge is true. 4 Wigmore, Evidence, §§ 1071-1072(Chadborn rev. 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick, supra, § 161. And the Supreme Court itself has consistently recognized this rule. "[T]he Court has consistently recognized that ... silence in the face of accusation is a relevent fact. .... Silence is often evidence of the most persuasive character." Baxter v Palmigiano, 425 U.S. 308, 319 (1976). And the rule is ancient. As Socrates cross-examined at his trial over 2000 years ago, "you are silent and have nothing to say. But is this not rather disgraceful, and a very considerable proof of what I was saying"? "I may assume that your silence gives consent." Apology in Plato 41,45(1942).

And concerning the Court's continuing silence year after year - "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v Hale, 422 U.S. 171, 176.

evidence, endorsed as an accurate indicator of truth by thousands of years of use, has special application in these circumstances. The charges are proved to be true, not only by the Court's silence year after year in the face of accusation, but also by the evidence, which independently proves the charges to be true.5/

5./ The Supreme Court has Hitler-like asserted to legalize killings defined as murder. This can not even be disputed, since it is mere historical fact. The only apparent defense is that- As Hitler was to Germany, so the Supreme Court is to America.

One of America's foremost constitutional scholars concluded "that the Justices are become a law unto themselves" and that their conduct "perilously resembles the subordination of 'law' to the attainment of ends desired by a ruling power which was the hallmark of Hitlerism." Berger, Government by Judiciary 408, 412 (Harvard University Press 1977).

The Weimar Constitution was patterned after ours. Hitler came to power within the terms of the Weimar Constitution. Thereafter he became "the supreme judge." United States v Altstoetter, supra, at 1011. Under the guise of interpretation, "the supreme judge" asserted to legalize killings which had been defined as criminal. The Nazi judges tried at Nuremberg claimed that they could not be held accountable for "murder" or "extermination" because they were "bound" by the "decrees" of "the supreme judge."

Will the U.S. Supreme Court now claim that it has the Hitler-like power to legalize mass murder?

Roe v Wade is another example to the world of how very powerful authorities, using pretense of law to clothe their criminal deeds, can overwhelm both the public mind, and the law of the land.

Moreover, under our government of laws, and not of men, judges are bound by a solemn legal duty which will not permit them to close their eyes and pretend that evidence does not exist. 6/ Thus, when judges of the

6./ Marbury v Madison, 1 Cranch 137. The judges can not substitute personal preferences for solemn laws derived from the consent of the governed. John Marshall held that for judges to swear to support the Constitution as the supreme law of the land, but then "close their eyes on the Constitution" and "condemn to death those victims whom the Constitution endeavors to preserve" is worse than "solemn mockery," it is a "crime." Id., at 179-180.

Judges have a legal duty to look at the evidence. A constitutional decision by the Supreme Court must be "always open to discussion when it is supposed to have been founded in error, and ... its judicial authority should hereafter depend altogether on the force of the reasoning by which it is supported." The Passenger Cases, 7 How. 282, 470 (1849).

Where there is an affirmative legal duty to act, the deliberate omission to do that duty, which results in death to others, can be prosecuted as homicide. Perkins, Criminal Law 602 (2d ed. 1969).

Albert Speer recognized this law when he became the only Nazi to plead guilty at Nuremberg. When he was warned of Auschwitz, Speer wrote that "I did not investigate- for I did not want to know what was happening there." "[F]rom fear of discovering something which might have made me turn from my course, I had closed my eyes." This "deliberate blindness" had made him guilty of complicity in extermination. Speer, Inside the Third Reich 376 (1970).

Thus, federal judges can be prosecuted if they close their eyes on the evidence, and permit victims to be executed, whom the law endeavors to preserve. This is a government of laws, and not of men.

United States are accused of mass murder, and the evidence is laid out in court, and pictures of the dead are shown to the judges, but year after year the judges do not deny the charges and prove them false, then not only an ancient law of evidence, but the solemn legal duty imposed by a government of laws, condemn this silence as equivalent to a confession that the charges are true.

The immediate practical result is that the U.S. Supreme Court has admitted that Roe v Wade is a mistake of law. By definition, the admission that Roe v Wade is a mistake of law is the legal equivalent of the express overruling of Roe v Wade. The legal status of Roe v Wade is just as if it had been expressly overruled, or never decided in the first place. It is no law at all.

And any judge of the United States, or any party, who chooses to close his eyes on these facts, unparalleled in the legal history of the world, and argues that the killings can

proceed without question, can be prosecuted for complicity in criminal extermination, including mass murder, just as if he had deliberately encouraged the killings after Roe v Wade was expressly overruled. 7/

7./ The Supreme Court asserted to legalize killings which were defined as criminal under positive criminal statutes, including murder statutes. If Roe v Wade were a mistake of law, then all the killings since 1973 can be criminally prosecuted. The ex post facto provisions of the U.S. Constitution do not apply to judicial decisions which are a mistake of law. Ross v Oregon, 227 U.S. 150 (1913). The general rule is that mistake of law is no excuse for breaking the law. Perkins, Criminal Law 920 (2d ed. 1969). The narrow exception of reasonable reliance on a court opinion thereafter determined to be a mistake of law does not apply to homicide cases. Model Penal Code, Tentative Draft No. 9, Comments § 2.04, page 138. In any event, "after a warning," such as given herein, a defendant can not claim that his reliance was reasonable. Id, at 138. And one can be criminally implicated in homicide by mere words of encouragement while the victims are being killed. Lafave and Scott, Criminal Law §§ 61, 64 (1972). And mistake of law is no excuse.

To illustrate the true status of Roe v Wade, suppose that a lawyer had accused "the supreme judge" of Nazi Germany of mass murder 50 times in court, but each time "the supreme judge" listened in silence and did not deny the charges and prove them false, and just continued the killings. Would such judicial conduct have warranted people in arguing that the killings could continue without question? The Nuremberg Court answered that question. Such argument is worse than mockery, or monstrous, it is an act of criminal extermination and murder.

Roe v Wade has been overruled. In the face of the facts, one must literally gamble life and liberty to support it. Mistake of law is no excuse for breaking the law. Many states still have the death penalty.

CONCLUSION

The Supreme Court has perpetrated one of the giant homicidal crimes in history on the United States. And the corruption of a judicial system for the accomplishment of criminal extermination involves an element of evil which is not found in frank atrocities which do not sully the judicial robes. The dagger of the assassin has been concealed beneath the robe of the jurist.

By its conduct, the U.S. Supreme Court has overruled Roe v Wade, 410 U.S. 113. Mere argument that the killings can continue can be criminally prosecuted. To save innocent lives from extermination, and uninformed persons from prosecution, the Supreme Court must expressly overrule Roe v Wade.

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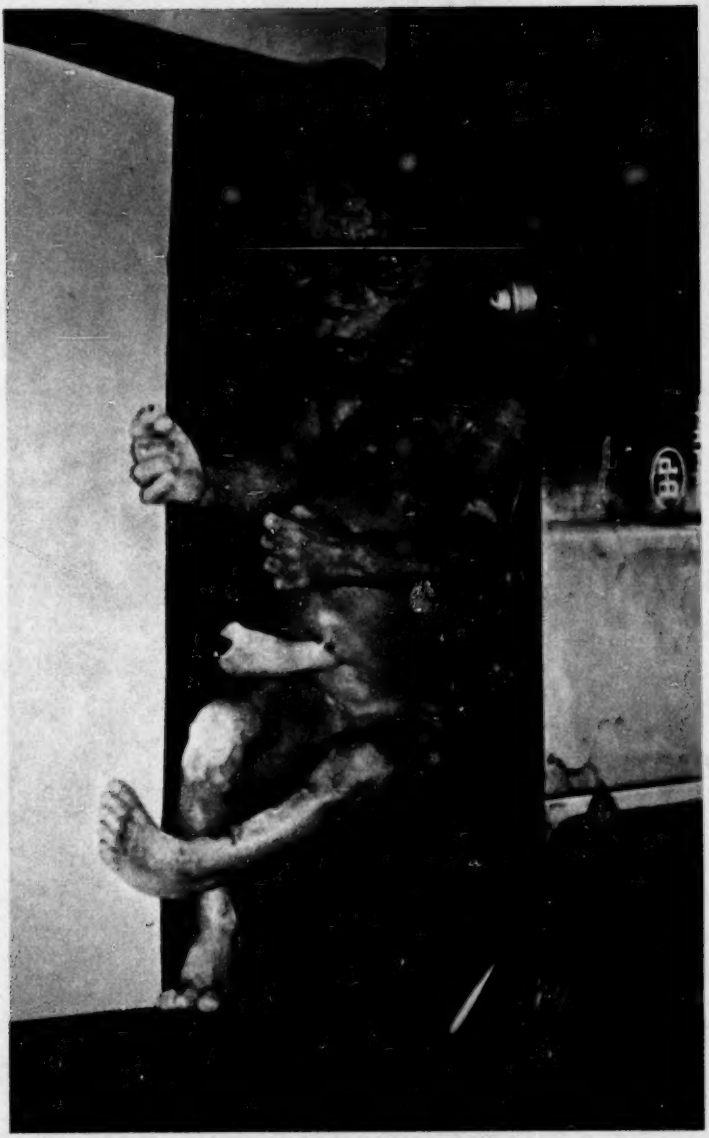
Alan Ernest
Counsel for Amicus



A-1

The photograph, supra A-1, shows a second stage abortion by prostaglandin. Such abortions not uncommonly result in the child being born alive.[1/] This Court could be prosecuted for murder for such a killing. There have been many thousands of such killings under Roe v Wade. And witnesses live to tell.

And if the child were killed in the womb and born dead, then this Court could be prosecuted for criminal extermination in violation of the Fifth and Fourteenth Amendments and 18 U.S.C. 242.[2/]

As the Court studies the face of this victim of Roe v Wade, let it contemplate that a government of laws shall be restored, and the law shall call the killers to account.

1./ Floyd v Anders, 440 F. Supp. 535,538(1977). The common second stage abortion techniques-hysterotomy, prostaglandin, and even salt poisoning-can result in the child being born alive. Jefferies & Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981.

2./ The amicus curiae brief by the Legal Defense Fund For Unborn Children shows that the unborn are persons whose lives are protected by the Fifth and Fourteenth Amendments of the U.S. Constitution.Thus their lives are also protected by 18 U.S.C. 242.

No. 81-746

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In The
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

CITY OF AKRON

vs.

AKRON CENTER FOR REPRODUCTIVE HEALTH

AKRON CENTER FOR REPRODUCTIVE HEALTH

vs.

CITY OF AKRON

PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

MOTION FOR LEAVE FOR AMICUS CURIAE TO PARTICIPATE IN ORAL ARGUMENT

ALAN ERNEST
P.O. Box 2471
Washington, D.C. 20013
(703) 437- 1178

COUNSEL FOR AMICUS CURIAE

CONTENTS

I. THE AMICUS MOVES THE COURT TO ALLOW ORAL ARGUMENT THAT ROE v WADE IS A MISTAKE OF LAW. THE PARTIES HAVE NOT DONE THIS. THIS CONSTITUTIONAL ISSUE IS SO FUNDAMENTAL THAT IF THE COURT AGAIN AFFIRMS ROE v WADE, BUT AGAIN REFUSES TO DEAL WITH THE VALIDITY OF ROE v WADE IN THE TEETH OF CHALLENGE, THEN IT CAN NOT BE PRETENDED THAT IT IS ANY LONGER THE GOVERNMENT OF THE UNITED STATES, OR ANY GOVERNMENT OF CONSTITUTION AND LAWS.....1

A. GROUND ONE. ROE v WADE IS A MISTAKE OF LAW BECAUSE THE COURT ASSERTED, WITHOUT ANY INVESTIGATION OF THE LAW OF MURDER, TO LEGALIZE KILLINGS WHICH HAD BEEN DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT 1

B. GROUND TWO. ROE v WADE IS A MISTAKE OF LAW SINCE IT IS BASED ON FALSE EVIDENCE, AND A FATAL REVERSAL OF THE BURDENS OF PROOF.....1

II. THE U.S. SUPREME COURT IS WILLFULLY USING UNCONSTITUTIONAL PROCEDURES TO MAINTAIN THE ROE v WADE KILLINGS 4

III. THE U.S. SUPREME COURT HAS CONFESSED IN COURT THAT IT IS GUILTY OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE.....4

IV. CONCLUSION 5

AUTHORITIES

Cases:

Baxter v Palmigiano, 425 U.S. 308 (1976).....5

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Dartmouth College v Woodward, 4 Wheat. 518 (1819).....2,3

Imbler v Pachtman, 424 U.S. 409 (1976).....4

Ross v Oregon, 227 U.S. 150 (1913).....5

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Yick Wo v Hopkins, 118 U.S. 356 (1886).....2,4

Texts:

Denman, Introduction to the Practice of Midwifery (1802).....3

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Velpeau, Complete Treatise on Midwifery (4th Am. ed. 1852).....3

Wigmore, Evidence (Chadborn rev. 1972).....5

U.S. Statute:

18 U.S.C. § 242 4

U.S. Constitution:

Fourteenth Amendment "Any Person" 1-3

Fifth Amendment Due Process.....4

MOTION FOR LEAVE FOR AMICUS CURIAE TO PARTICIPATE IN ORAL ARGUMENT

The Court is moved to allow the amicus curiae, THE LEGAL DEFENSE FUND FOR UNBORN CHILDREN, to participate in oral argument for the purpose of presenting the evidence which shows that Roe v Wade, 410 U.S. 113, is a mistake of law, and must be expressly overruled. This would dispose of all issues raised by the parties.

Only the amicus curiae has presented this issue; the parties did not do it. The grounds for determining that Roe v Wade is a mistake of law are presented in part I, infra.

I.

THE AMICUS CURIAE MOVES THE COURT TO ALLOW ORAL ARGUMENT THAT ROE v. WADE IS A MISTAKE OF LAW. THE PARTIES HAVE NOT DONE THIS. THE TWO GROUNDS PRESENTED ARE SO FUNDAMENTAL THAT IF THE COURT AGAIN AFFIRMS ROE v WADE, BUT AGAIN REFUSES TO HEAR THE TWO GROUNDS, THEN IT CAN NOT BE PRETENDED THAT IT IS ANY LONGER THE GOVERNMENT OF THE UNITED STATES, OR ANY GOVERNMENT OF CONSTITUTION AND LAWS.

A. Ground One

ROE v WADE IS A MISTAKE OF LAW BECAUSE THE COURT ASSERTED, WITHOUT ANY INVESTIGATION OF THE LAW OF MURDER, TO LEGALIZE KILLINGS WHICH HAD BEEN DEFINED AS MURDER SINCE LONG BEFORE THE ADOPTION OF THE FOURTEENTH AMENDMENT.

Without any examination of the law of murder, this Court in Roe v Wade asserted to legalize killings which had been defined as murder since long before the adoption of the Fourteenth Amendment.[1/] The Court has Hitler-like asserted to legalize murder. This is mere historical fact.

B. Ground Two

ROE v WADE IS A MISTAKE OF LAW SINCE IT IS BASED ON FALSE EVIDENCE, AND A FATAL REVERSAL OF THE BURDENS OF PROOF, AND THE UNBORN VICTIMS ARE BEING EXTERMINATED IN VIOLATION OF THE CONSTITUTION AND LAWS OF THE UNITED STATES.

The Supreme Court's conclusion in Roe v Wade, 410 U.S. at 158, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," is based on a fatal reversal of the burdens of proof and persuasion, and indispensable parts of the Court's supporting evidence are fabricated and false.[2/] The evidence

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1./ This evidence was incorporated in the Amicus Brief.

2./ This evidence was incorporated in the Amicus Brief and is summarized below for convenience. This evidence conclusively proves that the unborn are persons whose lives are protected by the Fourteenth Amendment, as follows:

A.

Even the Supreme Court admitted in Roe v Wade, 410 U.S. at 156-157, that if the

establishes, beyond the legal power of any judge of the United States to deny, that the unborn are persons within the language and meaning, the very express words as well as the spirit, of the

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unborn child "is a person within the language and meaning of the Fourteenth Amendment," then the case for a constitutional right to kill the unborn, as claimed in Roe v Wade, "of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

B.

The terms of the Fourteenth Amendment ("nor shall any state deprive any person of life ... without due process of law")(emphasis added) are "universal in their application." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). The words "any person" are universal and admit of no exceptions whatever. Thus, on their face, the words "any person" include the unborn, as everyone else.

C.

The holdings of Chief Justice John Marshall show that the Supreme Court had no lawful power to construe an exception to express, universal terms (such as "any person") unless the court can show that "the absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application." Sturges v Crowninshield, 4 Wheat. 122, 202-3. And the Court must further prove that "had this particular case been suggested" to the framers, "the language would have been so varied as to exclude it." Dartmouth College v Woodward, 4 Wheat. 518, 644-5. Chief Justice Marshall founded the universality of this court's own jusisdicton on these very rules. Cohen v Virginia, 6 Wheat. 264, 378-380. Thus, the Court bore an extraordinary burden to prove that if the case of the unborn had been brought to the attention of the framers of the Fourteenth Amendment, they would have varied the language to exclude the unborn and the Amendment would have been changed to effectively read that "Nor shall any state deprive any person, except unborn persons, of life ... without due process of law.

D.

The Supreme Court presented false evidence in Roe v Wade to support its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. And, but for the false evidence, there is not even a credible foundation, much less a compelling one, for creating an exception to the universal terms "any person" and denying the protection of the Amendment for the lives of the unborn.

At the time the Fourteenth Amendment was adopted in 1868, most states had already enacted positive statutes which made abortion a crime unless it were necessary to save the life of the mother. Within a few years, these criminal abortion statutes were virtually universal.

Consequently, any theory of a constitutional right to kill the unborn, as claimed in Roe v Wade, faced an impossible contradiction: How is it possible that the people who framed and adopted the Fourteenth Amendment had enacted positive criminal statutes to protect unborn life, but, at the same time, without a single word of explanation, intended to imply an exception to the express, universal terms "any person," and to imply a constitutional right to kill the unborn?

To resolve that fatal contradiction, the Court asserted the hypothesis that when the criminal abortion statutes were first enacted, the laws were not intended to protect unborn life, but rather were only intended to protect the mother. The hypothesis was falsely fabricated and used as follows.

1.

The Supreme Court first asserted, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v Wade, 410 U.S. at 148. This is asserted as fact.

The only authority cited by the Supreme Court to prove this assertion of fact was a 20th century medical history book, Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v Wade, supra, at 148 n.43. But this book merely described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The reference did not even mention abortion.

However, the 19th century authorities throughout the Western world prove the

of the Fourteenth Amendment, and thus the lives of the unborn are protected by the Amendment.

Court's assertion of fact to be false. These obstetric authorities, based upon their own experience in performing abortions, and from hundreds of cases reported from around the world, declared that the abortion operation, the operation of artifically evacuating the fetus from the womb, was "perfectly safe" to the mother. 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802). Or, "experience has proved that the dangers of the operation are reduced to a small matter." A.L.M. Velpeau, A Complete Treatise on Midwifery 530 (4th Am. ed. 1852). Or, "to the mother there is very little danger." H.L. Hodge, M.D., The Principle and Practice of Obstetrics 293 (1864). In short, the 19th century obstetric authorities prove the Supreme Court's assertion of fact to be false.

The Supreme Court never identified the "hazardous" abortion "procedure" to which it was referring. Actually the 19th Century physicians used the ancient method: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus" to "come on," which resulted in the expulsion of the fetus from the womb. 2 Denman, supra, 99. One 19th Century physician traced this operation back almost 2000 years. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

Consequently, the 19th Century physicians were using an ancient abortion procedure which they described as not hazardous to the mother. The Supreme Court did not examine even one single 19th Century medical textbook. And those medical texts prove its assertion of fact, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman," is false.

3.

The Supreme Court next asserted, "Abortion mortality was high." Roe v Wade, supra, at 149. This is also asserted as fact. The Supreme Court made this assertion without any authority to support it. It is likewise false. The 19th Century obstetric authorities expressly asserted that the abortion operation was not deemed to be hazardous to the mother. Consequently, the Court's assertion of fact, "Abortion mortality was high," is false.

4.

Upon these two false assertions of fact, the Supreme Court falsely infers that "a State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v Wade, supra, at 149. Thus a false inference is drawn from false assertions of fact.

5.

From the false inference that the criminal abortion laws were not intended to protect the lives of the unborn, the Court further falsely inferred that the framers of the Fourteenth Amendment did not intend it to protect the lives of the unborn, "that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v Wade, 410 U.S. at 158. This false conclusion is drawn from a false inference which is drawn from false facts.

6.

The Supreme Court bore the extraordinary burden of demonstrating that the absurdity and injustice of including the unborn within the universal terms "any person" would be "so monstrous, that all mankind would, without hesitiation, unite in rejecting the application." Sturges v Crowninshield, supra. And the Court bore the extraordinary burden of proving to a demonstration that if the case of the unborn had been presented to the Framers of the Fourteenth Amendment, "the language would have been so varied as to exclude it." Dartmouth College v. Woodward, supra.

But, the Court did not cite even one single 19th Century authority which expressly agreed with its conclusion that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn," much less one that expressly agreed that there was a constitutional right to kill the unborn as asserted in Roe v Wade. And the Court's assertion that the abortion laws were not intended to protect the lives of the unborn is shown to rest on false evidence. The authorities in law, medicine, and medical jurisprudence leave no doubt that these abortion laws were originally intended to protect the lives of the unborn. These statutes show that the framers and adopters not only intended the universal terms "any person" to include the unborn, but that they had enacted criminal laws to protect them in fact.

E.

Not only are indispensable parts of the Court's evidence false, but the Court

II.

THE U.S. SUPREME COURT IS WILLFULLY USING UNCONSTITUTIONAL PROCEDURES TO MAINTAIN THE ROE v WADE KILLINGS

The Supreme Court has decided many abortion cases on the merits, but the Court willfully (1) refused to allow counsel to especially represent the victims being killed, and(2) refused to allow the evidence in Roe v Wade, which it used to condemn the victims to death, to be cross examined, and (3) refused to allow new evidence to be presented on behalf of the victims being killed to establish their right to life under the U.S. Constitution.[3/] Under the Court's own rulings these procedures are unconstitutional[4/] and criminal.[5/]

III.

THE U.S. SUPREME COURT HAS CONFESSED IN COURT THAT IT IS GUILTY OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v WADE.

For the 57th time, the Supreme Court is accused of mass murder. For the 81st time, the Supreme Court is accused of exterminating millions of victims in violation of the Fourteenth Amendment and 18 U.S.C. 242. But the Court has not denied the charges and proved

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also fatally reversed the burdens of proof and persuasion described by Chief Justice Marshall, supra. The Court first decreed a constitutional right to kill the unborn. Roe v Wade, supra, at 153. Then, incredibly, after that death sentence was imposed, the Court subsequently examined the question of the inclusion of the unborn within the terms "any person." Roe v Wade, supra, at 158-9. Thus, in accordance with the compelling interest test, once the Court decreed a constitutional right to kill the unborn, the burden was shifted to the unborn to demonstrate the compelling justification of the criminal abortion statutes; that is, the burden was on the unborn to affirmatively prove that they were persons within the terms "any person " in the Amendment. And the Court placed the burden on the unborn to prove with "assurance" (that is, to make certain, and put beyond doubt) that they were persons within the Amendment, or the unborn would be excluded. This reversal of the burdens was not only fatal, but monstrous. Could the Court first decree a right to kill Jews, then place the burden on the Jews to prove with "assurance" that they were persons protected by the Constitution, and then upon false evidence or trifling objections, permit all Jews to be exterminated?

Rather the most difficult evidentiary burden in constitutional law was on the Court to prove with "assurance" that the unborn were not included within the terms "any person," or the unborn would be included. And the case for the unborn is far stronger than for many other groups, such as "strangers and aliens" and "corporations" which were included within the terms "any person" without the need of any independent corroborating evidence since the terms "any person" are "universal in their application." Yick Wo v Hopkins, supra. The terms "any person" include the unborn on their face; and the framers and adopters had enacted criminal statutes to protect the lives of the unborn in fact.

F.

The Supreme Court has violated the very letter of the Constitution, as well as its spirit, and condemned to death those victims whom the Constitution endeavors to preserve.

3./ Cases presented in Amicus Brief

4./ Cases presented in Amicus Brief

5./ Any judge who, under color of law, willfully deprives anyone of constitutional rights can be criminally prosecuted. Imbler v Pachtman, 424 U.S. 409. Since the unborn are persons within the terms "any person," their lives are, by statutory definition, also protected by 18 U.S.C. § 242.

them false. Under the Court's own rulings, its silence in the face of accusation, while looking at photos of the killed victims, [6/] can be taken as a confession that the charges are true.[7/] Such judicial conduct is the admission that Roe v Wade is a mistake of law as certainly as the express overruling of Roe v Wade. And this tacit overruling has the same legal consequences as an express overruling.[8/]

IV.
CONCLUSION

The court is moved to allow Amicus to appear at oral argument to present the evidence which proves that Roe v Wade is a mistake of law and must be expressly overruled.

Alan Ernest

Alan Ernest, Counsel for Amicus

6./ A photograph of the type killings complained about is included herein as Exhibit 1, infra A-1.

7./ Under "the tacit confession rule," McCormick on Evidence §§ 161, 171 (1972), failure to deny a charge is equivalent to a confession that the charge is true. 4 Wigmore, Evidence §§1071-1072(Chadborn rev. 1972). "Underlying the ruie is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick, supra, §161. And this Court has consistently recognized that ... silence in the face of accusation is a relevant fact. .... Silence is often evidence of the most persuasive character. Baxter v. Palmigiano, 425 U.S. 308, 319 (1976). And the rule is ancient. As Socrates cross-examined at his trial over 2000 years ago, "you are silent and have nothing to say. But is this not rather disgraceful, and a very considerable proof of what I was saying." Apology in Plato 41, 45 (Jowett transl. 1942). And concerning the Court's silence in the face of accusation year after year while the victims are being killed- "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v Hale, 422 U.S. at 176.

8./ The Supreme Court asserted to legalize killings which violated positive criminal statutes, including murder statutes. If Roe v Wade were a mistake of law, then all the killings since 1973 can be criminally prosecuted. The ex post facto provisions of the U.S. Constitution do not apply to judicial decisions which are a mistake of law. Ross v Oregon, 227 U.S. 150 (1913). The general rule is that mistake of law is no excuse for breaking the law. Perkins, Criminal Law 90 (2d ed. 1969). The narrow exception of reasonable reliance on a court opinion thereafter determined to be a mistake of law does not apply to homicide cases. Model Penal Code, Tentative Draft No. 4, Comments §2.04, at 138. In any event, "after a warning," such as given herein, a defendant can not claim that his reliance was reasonable. Id., at 138. And one can be criminally implicated in homicide by mere words of encouragement while the victims are being killed in violation of positive criminal statutes. Lafave and Scott, Criminal Law §§ 61, 64(1972). One must literally hazard life and liberty to argue in favor of the Roe v Wade killings in violation of criminal statutes. Blind faith in "the supreme judge" is no defense to criminal prosecution for complicity in murder. United States v. Altstoetter ("The Justice Case"), 3 Trials of War Criminals before the Nuremberg Military Tribunals.

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Nos. 81-746 and 81-1172

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Cross-Petitioners,

v.

CITY OF AKRON.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE NAACP LEGAL DEFENSE AND EDUCATIONAL FUND, INC., AS *AMICUS CURIAE*

JACK GREENBERG
JAMES M. NABRIT, III
JUDITH REED*
PENDA D. HAIR
Suite 2030
10 Columbus Circle
New York, New York 10019
(212) 586-8397

Attorneys for Amicus Curiae

* Counsel of Record

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Table of Contents

	Page
Table of Authorities.....	ii
Statement of Interest of *Amicus Curiae*.....	1
Summary of Argument.....	4
Argument.....	4

Page

Table of Authorities

Cases

Brown v. Board of Education, 347 U.S. 483 (1954)..... 5

Citizens Against Rent Control/ Coalition For Fair Housing v. Berkeley, ___U.S.___, 50 U.S.L.W. 4071 (December 15, 1981)..... 8

Coker v. Georgia, 433 U.S. 584 (1977)..... 2

Cooper v. Aaron, 358 U.S. 1 (1958)..... 10

Harper v. Virginia State Board of Elections, 383 U.S. 663 (1966)..... 8

In Re Primus, 436 U.S. 412 (1978)..... 8

Phillips v. Martin Marietta Corp., 400 U.S. 542 (1971)..... 2

Plessy v. Ferguson, 163 U.S. 537 (1896)..... 6

Reynolds v. Sims, 377 U.S. 533 (1964)..... 9

Page

Roe v. Wade, 410 U.S. 113 (1973)..... 5

Shapiro v. Thompson, 394 U.S. 618 (1969)..... 9

United States v. Carolene Products Co., 304 U.S. 144 (1938) 7

West Virginia Board of Education v. Barnette, 319 U.S. 624 (1943) 7

Constitutional Provisions and Statutes

U.S. CONST. AMEND. XIII 7

U.S. CONST. AMEND. XIV 7

U.S. CONST. AMEND. XV 7

42 U.S.C. §§ 2000e, et seq. 2

Other Authorities

Bryce, J. The American Commonwealth (2d ed. 1889) 7

Page

Kurland, P. and Cooper, G. (eds.). 49 Landmark Briefs and Arguments of the Supreme Court of the United States: Constitutional Law 377 (1975) 6

38 PHYLON 280 (September 1977) 4

Tocqueville, A. Democrary in America (H. Reeves trans. 1947) 7

U.S. BUREAU OF THE CENSUS, CURRENT POPULATION REPORTS, Series P-60, No. 119, Characteristics of the Population Below the Poverty Level: 1977 (1979) 3

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On Writs of Certiorari to The United States Court of Appeals For The Sixth Circuit

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BRIEF FOR THE NAACP LEGAL DEFENSE AND EDUCATIONAL FUND, INC., AS AMICUS CURIAE

==========

STATEMENT OF INTEREST OF AMICUS CURIAE

The NAACP Legal Defense and Educational

Fund, Inc., is a non-profit corporation established under the laws of the State of New York. It was formed to assist Black persons to secure their constitutional rights through litigation. Although the Legal Defense Fund's litigation program does not include cases involving abortion rights, the Fund is interested in any litigation which might result in formulating rules of law affecting rights of particular concern to Black people. The Fund has in the past participated in cases in which Blacks were not parties but the outcome of which might have important consequences for racial minorities. See, e.g., Phillips v. Martin Marietta Corp., 400 U.S. 542 (1971) (sex discrimination, outcome of case important for implementation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. §2000e et seq.); Coker v. Georgia, 433 U.S. 584 (1977) (capital

punishment for rape held unconstitutional; defendant was White but the penalty had been applied disparately against Blacks). The parties have consented to the filing of this brief and letters of consent have been filed with the Clerk.

Of primary concern to Amicus in this case is that the United States has proposed adoption of a rule of constitutional interpretation which, if adopted, would impair seriously the effectiveness of the Bill of Rights. We cannot help observing, also, that in view of economic realities an outcome of this case adverse to respondents-cross-petitioners could severely affect the poor, among whom Black women are represented disproportionately.[1/]

1/ The percentage of all Black women who live below the poverty level is approximately three times the percentage of White women living below the poverty level. U.S.

SUMMARY OF ARGUMENT

The Brief of the United States as Amicus Curiae urges the Court to accord "heavy deference" to legislative determinations in evaluating the constitutionality of burdens on fundamental rights which are particularly controversial. For the Court to establish such a precedent would seriously threaten the enjoyment of civil, political and personal liberties in the United States.

ARGUMENT

The case now before the Court concerns the constitutionality of a variety of state

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1/ continued

Bureau of the Census, CURRENT POPULATION REPORTS, Series P-60, No. 119, Characteristics of the Population Below the Poverty Level: 1977 p. 50 (1979). Moreover, Black women use legal abortion approximately twice as often as do White women. 38 PHYLON 280 (September 1977).

regulations that erect unduly burdensome and expensive obstacles in the paths of women seeking to exercise the constitutional right to terminate their pregnancies as recognized in Roe v. Wade, 410 U.S. 113 (1973). The Brief for the United States as Amicus Curiae advances the proposition that the Court should give "heavy deference" to the pronouncements of state legislatures regulating controversial fundamental constitutional rights, such as the right to abortion, and treats the regulations as mere public policy choices. Brief for the United States at 8-20.

The Brief of the United States is strikingly reminiscent of arguments encountered by Blacks and other racial and political minorities seeking vindication of their constitutional rights. For instance, during the oral argument in Brown v. Board of Education, 347 U.S. 483 (1954), counsel

for the State of Virginia maintained: "[T]he real crux of the whole matter is that there is involved fundamentally a policy question for legislative bodies to pass on, and not for the courts."[2/] Indeed, Plessy v. Ferguson, 163 U.S. 537, 550 (1896), held that the constitutionality of "separate but equal" was to be resolved by deciding "whether the statute of Louisiana [was] a reasonable regulation, and with respect to this there must necessarily be a large discretion on the part of the legislature."

The deference standard does not respect either the unique nature of constitutional rights in the United States or the role of the federal judiciary in resolving

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2/ 49 Landmark Briefs and Arguments of the Supreme Court of the United States: Constitutional Law 377 (P. Kurland and G. Cooper eds. 1975).

disputes over the exercise of those rights.[3/] In West Virginia Board of Education v. Barnette, 319 U.S. 624, 638 (1943) Justice Jackson, writing for the Court, recognized that:

> The very purpose of the Bill of Rights was to withdraw certain subjects from the vicissitudes of political contro-

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3/ The Bill of Rights, as well as the Thirteenth, Fourteenth and Fifteenth Amendments, were designed to protect individual and majority rights against encroachment by majoritarian rule. See, e.g., United States v. Carolene Products Co., 304 U.S. 144, 152, n. 4 (1938); A. Tocqueville, Democracy in America 158-159 (H. Reeves trans. 1947). Viscount Bryce, in commenting on the success of our federalism, lauded the role of the courts in our political system: "[B]y placing the Constitution above both the National and State governments, it has referred the arbitrament of disputes . . . to an independent body, charged with the interpretation of the Constitution, a body which is to be deemed not so much a third authority in the government as the living voice of the Constitution, the unfolder of the mind of the people whose will stands expressed in that supreme instrument." J. Bryce, The American Commonwealth, 348 (2d ed. 1889).

> versy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty, and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections.

The deference scheme now proposed would dangerously alter the delicate balance between individual rights and majoritarian sentiment.

Statutes or regulations that affect the exercise of a fundamental right have been always closely examined by the Court.[4/] Yet now, not only is the Court

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4/ The process has been variously characterized as close scrutiny, Harper v. Virginia State Board of Elections, 383 U.S. 663, 670 (1966) (right to vote), or "exacting scrutiny," In Re Primus, 436 U.S. 412, 432 (1978) (freedom of association), and is undertaken whenever a fundamental right is threatened. See Citizens Against Rent Control/Coalition For Fair Housing v. Berkeley, ___ U.S.___, 50 U.S.L.W. 4071, 4072 (December 15, 1981)("regulation of First Amendment rights is always subject to

asked to defer to the legislative determination of what constitutes an unconstitutional burden on a fundamental right, it is asked to believe that "[t]o the extent constitutional values were implicated, those values were taken into account because legislators like other public servants, take an oath to uphold the Constitution." Brief for the United States at 9, n.5. But that is true in every case. Nevertheless, this Court has recognized that the oath taken by state legislators has not always been sufficient protection for minorities in our society. The massive

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4/ continued

exacting judicial review"); Shapiro v. Thompson, 394 U.S. 618, 638 (1969) ("[t]he classification here touches on the fundamental right")(emphasis added); Reynolds v. Sims, 377 U.S. 533, 562 (1964) ("any alleged infringement of the right of citizens to vote must be carefully and meticulously scrutinized")(emphasis added).

resistance to the enforcement of the mandate of Brown, frequently led by state legislatures and other political authorities, must surely be considered one of the sorriest chapters in this nation's history.[5/]

The United States' brief suggests that the impact of its deference standard can be limited to a narrow range of cases "where the issue might be fairly characterized as involving either a choice among competing policy alternatives, or a pronouncement of constitutional principle ...." Brief for the United States at 15. Careful

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5/ The Court found the violence existing in Little Rock in 1958 to be "directly traceable to the actions of legislators and executive officials of the State of Arkansas, taken in their official capacities, which reflect their own determination to resist this Court's decision in the Brown case . . .." Cooper v. Aaron, 358 U.S. 1, 15 (1958).

consideration of its analysis, however, indicates that such a deference standard would apply to virtually every state and local action burdening any constitutional right. A "policy issue," in the brief of the government, is defined as one "subject to different views that are widely and fervently held." Id. at 13.[6/] It is difficult, if not impossible, to think of any

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6/ The United States' brief makes clear that the deference scheme would apply to constitutional rights other than privacy rights or the right to an abortion. See Brief for the United States at 17, n.13 (right to vote). Although the United States suggests that the courts need not "always yield to legislatures in areas of overlap between the power of each," id., at 15, the United States does not articulate any standards under which courts could determine when to defer to state or local legislative bodies. In fact, the rationale in support of the deference scheme offered by the United States is so devoid of content that it is impossible to view the United States' position as anything other than a general statement of political ideology.

issue involving a fundamental right or liberty that does not fit this mold.

This case deals with a fundamental right, albeit a controversial one. To now begin grading constitutional rights according to their controversiality would imperil our other basic constitutional rights. We strongly urge that the arguments proffered by the government be rejected by this Court.

Respectfully submitted,

JACK GREENBERG
JAMES M. NABRIT, III
JUDITH REED*
PENDA D. HAIR

Suite 2030
10 Columbus Circle
New York, New York 10019
(212) 586-8397

*Counsel of Record

Attorneys for NAACP Legal Defense and Educational Fund, Inc. as Amicus Curiae

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CITY OF AKRON, *et al.*,
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL ABORTION FEDERATION

JUDITH LEVIN
RABINOWITZ, BOUDIN, STANDARD, KRINSKY & LIEBERMAN, P.C.,
30 East 42nd Street
New York, New York 10017
(212) OX 7-8640

Attorneys for the National Abortion Federation

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTEREST OF AMICUS 1

SUMMARY OF ARGUMENT 7

ARGUMENT 10

POINT I LEGISLATION THAT INTERFERES WITH THE EFFECTUATION OF THE FUNDAMENTAL RIGHT TO CHOOSE ABORTION IS UNCONSTITUTIONAL UNLESS NARROWLY TAILORED TO MEET A COMPELLING STATE INTEREST 10

A. Regulations That Inhibit Access to Abortion Services Must Be Subjected To Rigorous Judicial Scrutiny. 15

B. Regulations That Hamper The Exercise Of Medical Judgment Burden A Woman's Right To Choose Abortion 18

POINT II SPECIFIC PROVISIONS OF THE AKRON ORDINANCE CANNOT WITHSTAND RIGOROUS JUDICIAL SCRUTINY . . 22

A. The Counseling Requirement Forces Patients To Receive Incorrect And Alarming Information Only From Physicians 23

B. The Parental Consent Requirement Unconstitutionally Fails To Permit Mature Minors To Consent To Abortion Or Allow Immature Minors Whose Best Interests Are Not Served By Parental Involvement To Obtain Abortions Without Their Parents' Knowledge. . 26

C. Restricting Second Trimester Abortions Unconstitutionally Restricts Access To Abortion And Fails To Protect Women's Health . . 30

CONCLUSION 36

TABLE OF AUTHORITIES

CASES

Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981) 30

Bellotti v. Baird (I), 428 U.S. 132 (1976) 18

Bellotti v. Baird (II), 443 U.S. 622 (1979) 18,26,27

Bigelow v. Virginia, 421 U.S. 809 (1975) 15

Brown v. Board of Education, 349 U.S. 294 (1955) 13

Brown v. Chote, 411 U.S. 452 (1973) 31

Carey v. Population Services International, 431 U.S. 678 (1977). 11

Colautti v. Franklin, 439 U.S. 379 (1979) 15,19

Cooper v. Aaron, 358 U.S. 7, 18-19 (1958) 13

Doe v. Bolton, 410 U.S. 179 (1973) . . . . . passim

Fusari v. Steinberg, 419 U.S. 379 (1975) 31

Gary-Northwest Indiana Women's Services, Inc. v. Orr, 451 U.S. 934 (1981) aff'g 496 F. Supp. 894 (N.D. Ind. 1980). . 31

Griswold v. Connecticut, 381 U.S. 479 (1965) 10

Harris v. McRae, 448 U.S. 297 (1980) 17

H.L. v. Matheson, 450 U.S. 398 (1981) 18,27

Maher v. Roe, 432 U.S. 464 (1977) 17

Mandel v. Bradley, 432 U.S. 172 (1977) 31

Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803). 12

Margaret S. v. Edwards, 488 F. Supp. 181 (E.D. La. 1980) . . 35

Martin v. Hunter's Lessee, 14 U.S. (1 Wheat) 304 (1806) . . 12

Michael M. v. Sonoma County, 450 U.S. 464 (1981) 26

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 15,16,25, 32,33,35

Roe v. Wade, 410 U.S. 113 (1973) . . . . . passim

Skinner v. Oklahoma, 316 U.S. 535 (1942) 10

United States v. Vuitch, 402 U.S. 63 (1971) 19

West Virginia Board of Education v. Barnette, 319 U.S. 624 (1943) 12,13,14

Whalen v. Roe, 429 U.S. 589, 604 n. 33 (1977) 19

OTHER AUTHORITIES

Foster, "Ambulatory Gynecologic Surgery," Ambulatory Care In Obstetrics and Gynecology, Ryan, G., Ed. (1980) 21

Henshaw, et al., "Abortion Services In The United States, 1979 and 1980," 14 Family Planning Perspectives No. 1, p. 5 (1982) 20

NAF, Minors and Abortion . . . 28, 29

INTEREST OF AMICUS

This brief is filed in support of the Akron Center For Reproductive Health, Inc., et al. by the National Abortion Federation (hereinafter NAF), a not-for-profit professional organization dedicated to preserving the right of all women to choose a safe legal abortion.[1/] NAF has more than 230 abortion clinic members in 41 states, the District of Columbia and Puerto Rico, including the Akron Center for Reproductive Health, the lead plaintiff in this case. NAF members also include physicians who provide abortion services in their offices

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1/ Counsel for the parties to this appeal have given their consent to the filing of this brief. Their letters of consent are filed with this Court.

as well as other organizations and individuals committed to the preservation and provision of safe legal abortions.

Founded in 1977 to fill the need for a national professional forum for abortion service providers, NAF provides a panoply of programs and services designed to guarantee high quality patient care and ensure access to safe and inexpensive abortion services.

NAF has promulgated exhaustive standards, formulated by special committees of practitioners and experts, on the medical, nursing, counseling, administrative and ethical aspects of abortion services. NAF standards are designed and implemented to promote the health, safety and psychological well-being of patients. They

are reviewed regularly and updated to reflect the most advanced knowledge in the field. NAF's current standards are set forth in full as an appendix hereto. Whenever possible, NAF works closely with health departments and legislative bodies in order to promote awareness of and conformity with these standards for quality care.

NAF periodically assesses the need and trends in the profession and provides several forums for the presentation of new information based on technological advancement, research and experience. NAF offers post-graduate medical seminars, accredited by the American Medical Association for continuing education credits, which concern the prevention and management

of complications of abortion. NAF also sponsors regional workshops in the areas of nursing, counseling, public affairs, and management.

NAF is a clearing-house of information to abortion service professionals and the general public on all aspects of abortion services. NAF distributes information on both the availability and cost of a variety of reproductive health services in addition to abortion, including fertility counseling, pre-natal care, home birthing, contraception and male and female sterilization. NAF also collects and disseminates information about violence against abortion providers and women seeking abortion in an effort to assist them in preventing violent attacks and managing them when they do

occur.

NAF undertakes specific research and publishes reports as part of its public education program. A special NAF task force recently published a report entitled Minors and Abortions, a copy of which has been lodged with the court. NAF also offers an information brochure, in English and Spanish, about abortion as well as printed guidelines on how to choose an abortion facility.

NAF has established the only national toll-free Hotline offering the general public and women seeking abortion information on a wide variety of subjects relating to abortion and reproductive health. NAF encourages feedback from Hotline consumers, and promptly investigates complaints about abortion providers.

More than 10,000 women and men -- teenagers, parents, husbands, social workers, teachers, ministers and even judges -- have used the Hotline service.

NAF does not promote the choice of abortion; rather it seeks to ensure that the means of effectuating that choice are both safe and accessible. NAF's Public Policy Action Program is designed to ensure continued access to safe legal abortion by educating the professional community and the thousands of men and women who daily visit NAF clinics across the country to meet the increasing threats to legal abortion.

NAF members provide approximately half of all the abortions in the United States. NAF constantly strives to assure that its members and the entire medical community have the tools and information

to provide the highest quality care to abortion patients. Thus, NAF opposes governmental attempts to interfere with and hamper the provision of quality medical and psychological care to abortion patients.

SUMMARY OF ARGUMENT

The Constitution guarantees that the fundamental right of privacy which includes the right to choose abortion cannot be eviscerated by anti-abortion factions in local legislatures. No law which directly interferes with a woman's access to abortion can withstand rigorous Constitutional scrutiny unless it is narrowly tailored to meet a compelling state interest.

Akron has enacted an explicitly anti-abortion and thoroughly unconstitutional

Ordinance, broadly drawn for the purpose of discouraging abortion and inhibiting access to abortion services.

The requirement that physicians personally counsel abortion patients prevents women from obtaining the benefit of medical judgment that trained counselors are best qualified to obtain truly informed consent and ensure that a woman's choice to terminate a pregnancy is uncoerced.

The parental consent requirement fails utterly to permit mature minors to make the abortion choice for themselves or to allow immature minors to avoid parental involvement when it is not in their best interests.

The restriction of second trimester abortions to hospitals fails to serve a

compelling state interest in women's health. Outpatient abortions even during the second trimester are now as safe as childbirth and in-hospital abortions. By restricting second-trimester abortions to hospitals when Akron hospitals fall woefully short of meeting the need for the service, Akron not only fails to promote women's health, it actually harms the health and well-being of women.

ARGUMENT

POINT I

LEGISLATION THAT INTERFERES WITH THE EFFECTUATION OF THE FUNDAMENTAL RIGHT TO CHOOSE ABORTION IS UNCONSTITUTIONAL UNLESS NARROWLY TAILORED TO MEET A COMPELLING STATE INTEREST

This Court has long recognized that the Constitution guarantees a fundamental right of privacy in matters of reproductive choice. Griswold v. Connecticut, 381 U.S. 479 (1965); Cf. Skinner v. Oklahoma, 316 U.S. 535 (1942)(the right to procreate is a fundamental constitutional right). In Roe v. Wade, this Court established that the "right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S. 113,

153 (1973). Because the right of privacy guarantees independence in making certain fundamental decisions about whether or not to bear a child, state regulations interfering with the effectuation of these decisions "may be justified only by a 'compelling state interest' . . . and . . . must be narrowly drawn to express only" that interest. Id. at 155. Laws that limit access "to the means of effectuating" decisions in matters of childbearing receive the same rigorous scrutiny as laws that prohibit choice altogether, since "access is essential to exercise of the constitutionally protected right." Carey v. Population Services International, 431 U.S. 678, 688 (1977).

The Constitution ensures that women's right to effectuate the abortion decision may not be eroded by state interference with the provision of abortion services. This Court has the power and the duty to invalidate state and federal statutes in conflict with the Constitution. Martin v. Hunter's Lessee, 14 U.S. (1 Wheat) 304 (1806), Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803).

When political turmoil threatens the enjoyment of fundamental constitutional rights, this Court must be especially vigilant to protect

> individual freedom of mind in preference to officially disciplined uniformity for which history indicates a disappointing and disastrous end.

West Virginia Board of Education v.

Barnette, 319 U.S. 624, 637 (1943); see also, Cooper v. Aaron, 358 U.S. 7, 18-19 (1958); Brown v. Board of Education, 349 U.S. 294, 299-301 (1955).

Mr. Justice Jackson, writing for the Court in Barnette, illuminates the vital necessity of protecting fundamental rights from erosion or extinction through the political process:

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. ...[F]undamental rights may not be submitted to vote; they depend on the outcome of no elections.
>
> Nor does our duty to apply the Bill of Rights to assertions of official authority

depend upon our possession of marked competence in the field where the invasion of rights occurs. True, the task of translating the majestic generalities of the Bill of Rights, conceived as part of the pattern of liberal government in the eighteenth century, into concrete restraints on officials dealing with the problems of the twentieth century, is one to disturb self-confidence.

* * *

But we act in these matters not by authority of our competence but by force of our commissions. We cannot, because of modest estimates of our competence . . . withhold the judgment that history authenticates as the function of this Court when liberty is infringed.

319 U.S. at 638-40.

A. Regulations That Inhibit Access to Abortion Services Must be Subjected to Rigorous Judicial Scrutiny

This Court has consistently applied the strict test enunciated in Roe v. Wade to state regulations that directly interfere with the right to choose abortion. Statutory provisions that create obstacles for a woman seeking abortion services burden her right to have an abortion. Unless such legislation is narrowly drawn to serve a compelling state interest, it is unduly burdensome and unconstitutional. Doe v. Bolton, 410 U.S. 179 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). Colautti v. Franklin, 439 U.S. 379 (1979). See also Bigelow v. Virginia, 421 U.S. 809 (1975).

Only those regulations imposing no "legally significant" obstacle to the effectuation of the abortion decision need not be subject to rigorous review. For example, Danforth upheld a requirement for written informed consent and certain reporting requirements because this Court found that neither provision presented any obstacle to a woman's ability to effectuate her decision to have an abortion. 428 U.S. at 66-68, 80-81. However, this Court explicitly cautioned states against informed consent and reporting provisions that burden the abortion decision and its effectuation. Id.

This Court has also upheld restrictions on government funding of abortions on the ground that refusal to subsidize abortions simply is not a state created obstacle to the effectuation of the

fundamental right to choose abortion. Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977). Finding that there was no fundamental right to Medicaid payments for abortions, this Court subjected the restrictions only to minimal review. Id. Neither Maher nor McRae affects the rigorous review required here. In both cases, this Court specifically distinguished funding restrictions from "direct state interference with a protected activity," and reiterated that rigorous review is appropriate where, as here, "the State attempts to impose its view by force of law...." Maher, 432 U.S. at 475-76; McRae, 448 U.S. at ____, 101 S.Ct. 2671, 2686-88.

This Court's decisions concerning minors' rights to abortion similarly do not dilute the heightened standard of

review applicable to direct state interference with all women's access to abortion. The cases holding that a minor's access to abortion is not coextensive with an adult's are grounded on special considerations applicable only to minors because of their youth. H.L. v. Matheson, 450 U.S. 398 (1981); Bellotti v. Baird (II) 443 U.S. 622 (1979); Bellotti v. Baird (I) 428 U.S. 132 (1976).

B. Regulations That Hamper The Exercise of Medical Judgment Burden a Woman's Right to Choose Abortion

Laws that encumber the physician's exercise of medical judgment in providing abortion services are as unconstitutional as statutes which directly obstruct a woman's access to those services. Doe v. Bolton, 410 U.S. 179 (1973). Although

recognizing the "presence of rascals in the medical profession as in all others", this Court has held impermissible legislation that cramps medical judgment because such legislation inevitably impinges on a woman's right to receive abortion services "in accordance with her licensed physician's best judgment." Id. at 197. See also, Whalen v. Roe, 429 U.S. 589, 604 n. 33 (1977).

This Court has consistently "underscored the importance of affording the physician adequate discretion in the exercise of ... medical judgment." Colautti v. Franklin, 439 U.S. 379, 387 (1979), citing Doe v. Bolton. See also, United States v. Vuitch, 402 U.S. 62 (1971).

Licensed physicians throughout the country have, over the last decade,

relied increasingly on freestanding abortion clinics to provide abortion services. The vast majority of abortions in this country are performed in freestanding clinics. Henshaw, et al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives No. 1, p. 5 (1982). Clinics not only provide high quality comprehensive medical care to abortion patients but assure the greatest access to abortion services at the lowest possible cost. Id. at 11. The health care team in abortion clinics, led by the physician, includes nurses, nurse practitioners and counselors or health advocates.

Abortion clinics not only best serve the needs of abortion patients but have provided a model for the delivery of outpatient surgical care in general. Only

recently have other surgical services become available on an outpatient basis. See, for example, Foster, "Ambulatory Gynecologic Surgery," "Ambulatory Care In Obstetrics and Gynecology, Ryan, G. Ed. (1980).

The physicians responsible for providing abortions have chosen to provide the services in freestanding clinics. States may not burden access to abortion services simply because clinics do not provide services in the traditional doctor-patient mode. Legislation that has the purpose and effect of discouraging the abortion choice and, if the choice is nonetheless made, of making abortion services more expensive and less accessible, directly interferes with access to abortion and inevitably has an adverse impact

on women's health and well-being. Such legislation impermissibly "limits" the right of women seeking abortion "to receive medical care in accordance with her licensed physician's best judgment." Doe v. Bolton, 410 U.S. at 197.

POINT II

SPECIFIC PROVISIONS OF THE AKRON ORDINANCE CANNOT WITHSTAND RIGOROUS JUDICIAL SCRUTINY

The provisions of the Akron Ordinance presented for review here deliberately interfere with women's ability to effectuate their right to choose abortion. The law is not narrowly tailored to meet any compelling state interest. To the contrary, it is broadly drawn to discourage abortion and inhibit access to abortion.

A. The Counseling Requirement Forces Patients To Receive Incorrect and Alarming Information Only From Physicians

Section 1870.06 of the Akron Ordinance forces physicians to recite to women seeking an abortion an anti-abortion litany of largely irrelevent and inaccurate "information." Requiring attending physicians to personally counsel their abortion patients impermissibly interferes with the exercise of their medical judgment, and their patients right to medical care in accordance with that judgment.[2/]

2/ Amicus does not address in detail the patently unconstitutional substantive information requirements amply briefed by plaintiffs and other amici. Indeed, the City of Akron virtually concedes the unconstitutionality of these requirements, arguing instead that they should be severable.

Physicians have recognized that the traditional doctor-patient dialogue is not the only or even the best way to ensure that a patient gives informed consent to surgery. Many doctors have rejected the traditional model in favor of comprehensive counseling services provided by trained counselors. Abortion counseling is designed not only to provide patients with information concerning the abortion procedure but also to ensure that their choice to have an abortion has been freely made without coercion. See NAF Counseling Standards at A-8 through A-13.

Counseling by specially trained counselors is a particularly innovative practice in the delivery of abortion services. There is no other medical setting that offers such an opportunity

for educational and emotional guidance from specially trained non-physician staff. Because they are not physicians, counselors are less intimidating to patients who are more willing to talk openly to counselors. Counselors are less inclined than doctors to use abstruse and technical language so patients understand counselors more easily.

This Court has warned that states may not use informed consent requirements to "confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 67 n. 8 (1976). By forcing physicians to personally counsel their abortion patients, Akron impermissibly restrains physicians and denies their abortion patients the right

to counseling services in accordance with their doctors' best medical judgment.[3/]

B. The Parental Consent Requirement Unconstitutionally Fails To Permit Mature Minors To Consent To Abortion Or Allow Immature Minors Whose Best Interests Are Not Served by Parental Involvement To Obtain Abortions Without Their Parents' Knowledge

This Court has repeatedly recognized how devastating unwanted pregnancy can be for teenagers. Michael M. v. Sonoma County, 450 U.S. 464 (1981), Bellotti v. Baird, 443 U.S. 622 (1979).

Accordingly, although recognizing an important state interest in encouraging

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3/ Akron's efforts to restrict medical judgment as to appropriate counseling services would likely have the no doubt intended side effects of reducing the availability and driving up the cost of abortion services. Physicians forced to spend time in extensive counseling sessions will be able to perform abortions for fewer patients. These patients able to receive services will inevitably have to bear an increased cost.

pregnant minors to consult their parents, this Court struck down a statutory scheme which even provided a judicial alternative to parental consent because the law failed to provide a complete by-pass to parental involvement in the abortion decisions of mature minors and those immature minors whose best interests would not be served by parental involvement. Bellotti v. Baird, 443 U.S. 622 (1979). See also H. L. v. Matheson, 450 U.S. 398 (1981), (Powell, J., concurring).

Like the Massachusetts Law held unconstitutional in Bellotti (II), the Akron Ordinance fails to account for the right of mature minors to make the abortion decision for themselves or to protect even the immature minor for whom parental involvement would be harmful.

The law also fails to provide a quick and confidential procedure to secure judicial authorization for an abortion.

NAF endorses encouraging young pregnant women to involve their parents in their decision whenever possible and recognizes that "[i]n most cases, parents are supportive of their daughters in time of crisis and decision." NAF, Minors and Abortion at 24. However, in those cases where parental involvement would be harmful, it is crucial that the young pregnant woman be permitted to obtain an abortion without her parents' knowledge and be able to secure that permission without delay.

Minors are, for a variety of reasons, more likely to delay seeking the abortion than older women. Minors

and Abortion at 13. Minors, because of their youth, are less likely to recognize signs of pregnancy, less sophisticated about access to health care, less likely to have ready financial resources, and more frightened of revealing their plight. Id. If their own delay is exacerbated by state created delays in securing judicial authorization, the risk to their health is staggering. Id.

The Akron Ordinance fails utterly to account for mature minors or to protect the immature whose best interests would not be served by parental involvement. The law does not, as the Constitution requires, meet the needs of young women coping with unwanted pregnancy.

C. Restricting Second Trimester Abortions Unconstitutionally Restricts Access To Abortion and Fails To Protect Women's Health

Akron's restriction of second trimester abortion procedures to hospitals not only directly interferes with effectuation of the abortion decision, it precludes the second trimester abortions for many women because Akron hospitals do not begin to meet the need for the service. See Akron Center For Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1209 (6th Cir. 1981). Moreover, it substantially increases the cost of the service to those few women who will be able to obtain second trimester abortions in Akron. Id.[4/]

4/ The Sixth Circuit held that although the second trimester restriction unduly burdened access to abortion, it was bound by Gary-Northwest Indiana Women's Service, Inc. v. Orr, 451 U.S. 934 (1981), aff'g

(Fn. continued next page)

(Fn. continued from preceding page)
496 F. Supp. 894 (N.D. Ind. 1980) to uphold the provision. 651 F.2d at 1210. In Gary-Northwest, this Court summarily affirmed the refusal of a three-judge court to vacate its earlier judgment and enjoin an Indiana statute restricting second trimester abortions to hospitals.

Summary affirmances reject only the specific challenges presented in the jurisdictional statement. Mandel v. Bradley, 432 U.S. 173, 176 (1977), Fusari v. Steinberg, 419 U.S. 379, 391-393 (1975). (Burger, C.J. concurring). The questions presented in Gary-Northwest went to procedural issues not relevant here. The only arguably substantive issue presented in Gary-Northwest was "whether the lower court had abused its discretion in failing to issue a preliminary injunction." No. 80-1275, Jr. St. at i (emphasis added). "In reviewing...interlocutory relief, this Court ...intimate(s) no view as to the ultimate merits..." Brown v. Chote, 411 U.S. 452, 457 (1973).

Unlike the Indiana statute at issue in Gary-Northwest, Akron's second trimester restriction was fully litigated at a trial on the merits. Moreover, the Indiana statute, in sharp contrast to this one, defined hospitals to include ambulatory outpatient surgical centers.

Thus, the summary affirmance in Gary-Northwest is not precedent here.

In Roe v. Wade this Court, on the basis of evidence of the relative safety of abortion and childbirth then available, held that, because second trimester abortions were then less safe than childbirth,

> ...the state's important and legitimate interest in the health of the mother [becomes] "compelling..., in light of present medical knowledge,..." at approximately the end of the first trimester.

410 U.S. at 163 (emphasis added). Roe accordingly held that states could regulate abortions in the second trimester, but only to further "the preservation and protection of maternal health." Id.

In Danforth, this Court, utilizing the strict scrutiny applicable to all laws impinging on fundamental rights, struck down a Missouri statute banning saline infusion procedures in the second trimester because

it had the effect of virtually eliminating access to second trimester abortions and was not narrowly tailored to preserve women's health. 428 U.S. at 79.

Application of the rigorous scrutiny mandated by Danforth to the hospital restriction here requires its invalidation notwithstanding the suggestion in Roe v. Wade that restricting second trimester abortions to hospitals or specially licensed clinics might be constitutional. 410 U.S. at 163. There, this Court relied heavily on the policy of the American Public Health Association ("APHA") recommending a hospital setting for second trimester abortions which was based on the risks associated with the technology available at that time. Id. at 144-146, 163.

Since Roe v. Wade was decided, technological advances in the provision of second trimester abortions, pioneered by NAF members, have resulted in the availability of safe second trimester abortions on an outpatient basis. For example, Dilation and Evacuation (D&E) abortions, which were virtually unknown in 1973, are available on an outpatient basis during the second trimester and safer than childbirth. The APHA has accordingly changed its policy to recommend outpatient second trimester services, and, like NAF, is urging this Court to strike down Akron's second trimester hospital restriction. See, brief Amicus Curiae of APHA. The briefs of the American College of Obstetrics and Gynecology and the American Medial Association and of the Planned Parenthood Federation of America, among others, also docu-

ment the safety of outpatient second trimester abortions and support the position urged here.[5/]

Like the saline ban in Danforth, Akron's hospital restriction cannot withstand rigorous scrutiny and

> ...fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after he first 12 weeks.

428 U.S. at 79.

5/ The technological strides made since Roe suggest that the state's interest in maternal health may not become compelling and justify any regulatory obstacle until the end of the second trimester of pregnancy. See Margaret S. v. Edwards, 488 F. Supp. 181, 194-196 (E.D. La. 1980).

CONCLUSION

For the reasons stated above this Court should hold unconstitutional all of the Akron ordinance provisions restricting access to abortion services.

Respectfuly submitted,

JUDITH LEVIN
RABINOWITZ, BOUDIN,
STANDARD, KRINSKY,
& LIEBERMAN, P.C.
30 East 42nd Street
New York, New York 10017
(212) 697-8640

Attorneys for the
National Abortion
Federation

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NATIONAL ABORTION FEDERATION

STANDARDS

National Abortion Federation
110 East 59th Street
New York, NY 10022

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TABLE OF CONTENTS

Foreword..... A-1
Preamble..... A-5
Counseling Standards..... A-8
Philosphy of Counseling..... A-8
Objectives of Counseling..... A-9
Qualifications of Counselors..A-11
Training and Supervision..... A-12
Nursing Care Standards..... A-14
Objectives..... A-14
Qualifications of Nursing Staff.....A-14
Training of Nursing Staff.....A-18
Medical Care..... A-20
Pre-operative Care.....A-20
Operative Care..... A-22
Postoperative Care..... A-24
Drugs and Medications..... A-25
Equipment and Physical Plant. A-26
Medical Personnel..... A-27
Second Trimester Procedures.. A-28
Emergency Protocol..... A-30
Ethical Standards..... A-34
Determination of Gestational Age..... A-34
Policy Statement on Delay of Abortion..... A-34
Provision for Financial Assistance in Case of Complications... A-35
Public Assistance Funds..... A-36
Fee Schedules..... A-36
Adminstrative Procedures..... A-38
Personnel Policies and Procedures..... A-38
Clinic Security..... A-40
Patient Fees and Records..... A-40
Confidentiality..... A-41
Minors..... A-43
Administrative Supervision... A-43
Reporting Standards..... A-46
Referral Standards..... A-49

FOREWORD

While the National Abortion Federation is an organization specifically committed to questions of the provision of quality abortion services for women, it recognizes that education about abortion procedures and services should be the responsibility of all health agencies and professionals concerned with the care of women. Health professionals in every state should accept this educational responsibility. These agencies and individuals should assume a leadership role in making essential facts known to the public, other health professionals and non-professionals who have contact with individuals in need, and members of all branches of government who must make

informed decisions about the role of abortion in our society. The facts are:

* Women should be as free as possible in their personal choice involving abortion and should not be coerced in any way.

* Individuals contemplating abortion should be encouraged to seek information and counseling from the best available source.

* Educational literature on abortion should be easily obtainable. Such literature should indicate the means by which individuals obtain information and services, describe the current legal status of abortion, discourage individuals from seeking a dangerous illegal abortion, emphasize the availability of contraception as a means of avoiding unwanted pregnancy, make

available information regarding Medicaid, other insurance coverage, and other sources of funds for those in need; and supply information on the availability of contraception and male or female sterilization.

* Both risks and costs are less when abortion is sought early in pregnancy.

* The symptoms of pregnancy should be widely known so that those wishing to terminate an unwanted pregnancy may seek assistance at the earliest stage of pregnancy. Since the risks of complications are lowest in early pregnancy, the early detection of pregnancy and determination of appropriate management should be encouraged.

* The diagnosis of pregnancy should be confirmed prior to abortion through the

performance of adequate physical examination and reliable laboratory tests for pregnancy.

* If travel to another community for an abortion is contemplated, patients should confirm the actual presence and stage of pregnancy before travel plans are made.

* Abortion should be legally performed by or under the supervision of licensed physicians who have been adequately trained to prevent, recognize, and treat the complications which may ensue.

* Adequate followup care, which includes the identification and knowledge of specific contacts for post-procedure medical services, is essential to the prevention and detection of post-abortion complications.

PREAMBLE

Abortion is a health service and should be provided to the public with the same attention to standards of safety, effectiveness, and regard for patient rights as other health services. Abortion services are an integral part of comprehensive family planning and maternal and child care.

The availability of safe abortion services to all who need them is essential to community health, personal freedom, and individual dignity. The National Abortion Federation is committed to the provision of these services under humane circumstances whenever and wherever they are offered.

In order to insure that these purposes are fulfilled, we believe that standards in abortion services should be

followed in the areas of counseling, nursing, medical and surgical procedures, informed consent, followup care, ethics, administration, reporting and referral.

The rigorous maintenance of high standards of care does not preclude the development of new techniques and innovative methods of service delivery that achieve quality care.

Where a facility departs from a stated NAF standard, the facility is expected to provide full documentation of the alternative they have chosen and demonstrate its effectiveness in fulfilling the intent of the standard in question.

All underlined sections in this document are obligatory standards for NAF member facilities and must be current practice for membership in good standing.

All other sections are advisory and strongly recommended.

COUNSELING STANDARDS

Philosophy of Counseling

Decision counseling seeks no pre-determined outcome, but encourages exploration of all possible alternatives, the final choice resting entirely with the woman. By establishing a relationship based on empathetic understanding and non-judgmental support, the counselor attempts to assist women as necessary with decision making, anxiety reduction, and informed consent. The woman's autonomy and control should be supported to the fullest. The counseling contract should be agreed upon by the woman and the counselor at the beginning and should clearly identify the counseling objectives. These should be distinguished from other issues and objectives such as the provision of

information.

It should be assumed, unless evidence is otherwise presented, that the woman is mentally competent. Like other major life decisions, decisions around pregnancy may involve confusion, ambivalent feelings, and value conflicts which make counseling an important part of the service provided. However, it does not mean necessarily that the woman is sick or helpless. Counseling should be offered but not imposed, and it should not constitute a barrier to appropriate service. Counseling should always be consistent with the needs of the woman.

Objectives of Counseling

The following objectives must be fulfilled in response to the need of the individual woman and should be accomplished on an individual basis in

privacy. The opportunity for individual counseling must be offered to every woman:

* to assist the pregnant woman, as needed, in exploring her feelings about her pregnancy, her circumstances, and her options;

* to assist the woman, as needed, in decision-making by helping her face the task of choosing, encouraging a careful examination of all options, providing accurate information, and supporting her right to choose for herself, free of all coercion so that she retains her sense of autonomy and control;

* to refer, when appropriate, for implementation of the woman's choice or for further counseling or additional medical services.

The following objectives must be

fulfilled with every woman who chooses abortion and may be accomplished either on an individual basis or in group sessions, providing that attendance at a group session is voluntary:

* to insure informed consent by establishing that the patient is mentally competent and appears to understand the nature and consequences of the procedure;

* to prepare the woman for surgery in a manner that facilitates her safety and comfort;

* to offer the woman an opportunity to understand her fertility, to assist her in reaching a decision about the method of contraception she will use, if any, and respecting her choice.

Qualifications of Counselors

The counselor should be an empathetic, responsive, caring person who

understands how to discipline herself in order to be helpful to others.

She should be comfortable with her own sexuality and nonjudgmental in her attitude toward the sexuality of others.

She should understand how to help a woman make health care decisions and be able to distinguish those decisions from moral and medical judgments, which have no place in the counseling session.

She should understand and observe a professional code of ethics.

She should be receptive to supervision and to training in counseling skills and family planning practices.

Training and Supervision

Counselors must be provided initial training that covers at least the following topics in detail:

* sexual and reproductive health

* abortion technology
* contraceptive technology
* short-term counseling skills
* community resources and referrals
* informed consent
* agency policies and practices

NURSING CARE STANDARDS

Objectives

The objectives of abortion nursing services include:

* the use of the nursing process to assist each patient in reaching her highest level of emotional and physical well-being before, during, and after her abortion;

* the provision of each patient with basic knowledge about her health so that she may make informed choices regarding her own health care;

* the provision of a safe and health-promoting environment for each patient.

Qualifications of Nursing Staff

The nursing staff includes appropriately trained health workers including but not limited to each

licensed professional, practical, or vocational nurse.

Each staff person providing nursing care must acknowledge and practice within her professional and/or prepratory limits.

Those responsible for nursing care must be skilled in inter- personal communication. These skills include interviewing, crisis intervention, support, and health education. They must exhibit skill in direct patient care, surgical nursing, sterile technique, and the documentation and reporting of these actions.

Each person responsible for nursing functions must understand the basics of reproductive physiology, have a knowledge of contraceptive technology, and have an understanding of the mode of action,

adverse effects and contraindications of medications being dispensed. Each must understand the proper operation and routine maintenance of all medical equipment used. In particular, each must be familiar with the location and proper use of emergency medications and equipment. Knowledge of the emergency protocol and procedure as set forth by the medical director is essential.

Nursing care providers must be sensitive and empathetic to the unique needs of each individual patient and must be committed to maintaining a pro-choice, non-judgmental attitude. They must understand the flow of patients within the facility in order to assure the routine provision of appropriate medical care. They must participate as active members of the health care team.

Those staff members functioning in an expanded nursing role must operate within the limits of written, current and signed medical orders and/or within written protocols and procedures. They must demonstrate an understanding of the implications of their clinical findings, have direct access to medical consultation, and be supervised by a physician licensed in the state in which the practice occurs.

Supervision of Nursing Care

Nursing care must be supervised by a registered nurse or physician. The nursing care supervisor must be capable of directing response in emergency situations, and must participate actively as a member of the health care team. A nurse, physician, or appropriately competent and licensed medical person

must be present in the facility while abortions are being performed and during the time the patients are recovering.

Training of Nursing Staff

Nursing care providers should be provided with a training and orientation period appropriate to the needs and level of preparation of each individual.

The orientation should include information concerning:

* preoperative, operative, and postoperative abortion nursing procedures;

* reproductive anatomy and physiology;

* sexual health;

* current contraceptive technology;

* emergency procedures;

* sterile technique;

* documentation and charting;

* agency policies;

* nursing's role as part of the health care team;

* stress management.

MEDICAL CARE

Quality abortion services should be readily available to all patients who desire these services. Abortion should be an integral part of medical education and of residency training in obstetrics and gynecology and in family practice. Important factors related to the incidence of complications with abortion are the skill and experience of the operating practitioner and the presence of a well-educated supporting staff.

Customary surgical principles dictate the following standards for an abortion faciity:

Pre-operative Care

* An adequate preoperative history and physical examination must be conducted, to include:

an accurate determination of the

duration of gestation;

the identification of any pre-existing conditions or complications; and

the detection of any factors which could influence the choice of procedure, anesthesia, or the pre- and post-operative management.

* Urine testing for pregnancy is essential except when a positive diagnosis of pregnancy has been established by other means such as diagnostic ultrasound. Laboratory procedures to determine hematocrit and Rh factor in every case are mandatory. The desirability of other laboratory procedures will depend upon the population served. These may include sickle cell testing, endocervical and anal culture for gonorrhea, urinalysis, serologic test for syphilis, and when

indicated, cytologic screening for cancer.

Operative Care

* Abortions must be performed only by licensed physicians or by non-physicians who are permitted to do so by applicable law who perform abortions under the supervision of a licensed physician. All personnel performing abortions must have received prior special training in the performance of abortions, and in the prevention, recognition, and treatment of the complications which may ensue.

* All practitioners must work under a Medical Director who is a licensed physician. It is mandatory that the Medical Director or facility have a working arrangement with a physician who has admitting privileges at a local

hospital in order to insure the necessary back- up for medical complications.

* General anesthesia must be given by an anesthesiologist or nurse anesthetist with a physician trained in the treatment of anesthesia complications on the premises.

* Every reasonable effort must be made to evacuate the uterus completely. All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for

microscopic examination. The laboratory discovery of tissue other than that usually associated with uncomplicated intrauterine pregnancy must be reported within 48 hours to the abortion service of operating practitioner for appropriate followup (e.g. trophoblastic disease; suspected ectopic pregnancy). There must be an appropriate mechanism for contacting the patient and informing her of the significance of the report.

Postoperative Care

* The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area. The staff/patient ratio in the recovery area should be appropriate and adequate with regard to the anesthesia used. A physician must be immediately available to the facility as

long as there are patients in the recovery area.

* Prior to discharge, postoperative care should be directed toward confirming that the patient is at minimal risk of serious complications. Periodically, the patient's pulse rate, blood pressure, and external bleeding must be examined for evidence of intra-abdominal bleeding or injury. These observations should be made during the postoperative period, the length of which is partly dependent upon the operative procedure employed. If systemic drugs are used for analgesia/anesthesia, the patient must be fully reactive before discharge.

* The facility must provide continued contact for an availability of postoperative care on a 24-hour basis.

Drugs and Medications

* Drugs, parenteral fluids, and electrolyte solutions must be available in sufficient supply. Physiologic solutions (i.e. normal saline, Ringer's lactate) should be available for use during intravenous infusion of oxytocin. Rh-immune globulin must be explained and administered to Rh-negative patients. Fully informed consent must be obtained from those refusing. Narcotic antagonists must be available when parenteral narcotics are used.

Equipment and Physical Plant

* The facility must have the necessary equipment and gases (including oxygen) for artificial ventilation and for cardiac and pulmonary resuscitation.

* The operating table or conventional gynecologic examining table with accessories must be located in a

room of adequate dimensions, illumination, and ventillation.

* Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure and adequate to perform conventional cervical dilatation and curettage. Equipment for vacuum aspiration must be electrically safe and designed to prevent reverse pump action.

* The facility must have the capability to transfer a patient immediately to a hospital operating room for emergency care.

Medical Personnel

* It is the responsibility of the facility to provide for periodic, systematic, and confidential peer review of all practitioners performing abortions and other procedures (e.g. IUD

insertion). This review will include a minimum of:

* observation of operative technique;

* review of complications;

* review of a reasonable random sample of each practitioner's charts;

* review of each practitioner's interaction with patients.

Second Trimester Procedures

All provisions stated above will apply to second trimester procedures, and the following additional standards will be observed:

* Counseling services specifically oriented to the needs of second trimester patients must be available.

* The use of diagnostic ultrasound prior to termination of second trimester pregnancy is highly advisable for

determination of fetal age.

* If a dilatation and evacuation (D&E) procedure is performed under general anesthesia, it is advisable for it to be performed on the premises of a full-service hospital.

* All second trimester procedures performed on an outpatient basis must have immediate access to a full-service hospital within 15-20 minutes door-to-door.

* The procedure must be performed by a licensed physician who has been specifically trained in the performance of this procedure.

* A patient having saline amnioinfusion abortion must be supervised carefully during saline infusion and during oxytocin stimulation to prevent

electrolyte imbalance.

* Fetal expulsion must be planned for occurrence in a medically safe environment such as a hospital or specially equipped clinic facility.

* In amnioinfusion abortion, the patient must be evaluated within two hours after fetal expulsion to determine whether expulsion of the placenta has occurred.

* Nursing services specifically oriented to the needs of second trimester patients must be available for their care.

Emergency Protocol

* Each facility must have a written protocol for emergency evacuation of patients and should conduct regular drills.

* In the evacuation of a patient, medical personnel from the facility should accompany the patient.

* If an ambulance service is not immediately available, the faciity must maintain emergency transportation.

* The Medical Director is responsible for assuring that the patient is properly admitted to the hospital and has competent care from that point.

* All medical staff members must be proficient in cardiopulmonary resuscitation and it is highly advisable that other staff members be proficient in CPR.

* Drugs should be available for the following complications:

cardiac arrest

seizure

asthmatic attack

allergic reaction

narcotic toxicity

hypovolemic shock

* Emergency medications should include:

Narcan R

epinephrine

phenobarbitol injectable USP

Benadryl R

aminophilline

* The following emergency equipment must be available and checked for proper function at regular intervals:

plastic airway

resuscitation bag

cardiac arrest board

defibrillator if general anesthesia is administered

laryngoscope

endotracheal tube

large bore IV catheter needles

IV fluids, tubing and support

oxygen

Determination of Gestational Age

Because the safety of abortion is partly dependent upon the stage of gestation at which it is performed, abortion providers have an obligation to determine gestational age as accurately as possible prior to the choice of procedure. This is particularly important in the later stages of the midtrimester (after approximately 19 weeks LMP).

Policy Statement on Delay of Abortion

The National Abortion Federation recommends that whenever practical, an abortion should be performed within one week of the request to terminate the pregnancy. This includes women who are unable to pay at the time they seek an abortion. It is especially critical that

women not be delayed in having abortions during the 12th through 16th menstrual weeks of gestation.

Should an abortion facility not be able to provide a dilatation and evacuation (D&E) procedure during this interval, it is the facility's obligation to refer women immediately to facilities where such procedures are performed in accordance with NAF standards. Should referral not be possible, women must be informed of the increased risk in delaying until the 17th menstrual week of gestation.

It is the responsibility of abortion facilities, medical schools, and teaching hospitals to train physicians to perform the D&E procedure used during this interval.

Provision for Financial Assistance in

Cases of Complications

An abortion facility should have prior adequate financial arrangements, detailed in a written protocol, to be able to compensate patients who have suffered damages as a result of malpractice. This can include insurance, reserves, or other responsible options.

Public Assistance Funds

In order to fulfill Article II of the NAF Bylaws, members should pursue all possible efforts to be able to receive public assistance funds for both abortion procedures and/or the ancillary services related to abortion and family planning. This includes filing the necessary forms and compliance with state and local regulations for reimbursement.

Fee Schedules

All member facilities mu

prominently display patient fees at reception and cashier offices, indicating services included.

ADMINISTRATIVE PROCEDURES

Personnel Policies and Procedures

NAF member facilities must provide vacation and sick leave benefits for full-time staff members. NAF recommends an annual vacation leave of two weeks (10 days) and sick leave of one day per month (12 days annually). Health insurance coverage is also recommended for employees of NAF member facilities. A written job description including an outline of duties and qualifications should be available for each position. The job descriptions should be updated as duties change.

Performance appraisals should be in writing with the supervisors' and employees' signatures. Performance appraisals should be kept in the employee personnel folder along with other

information pertaining to that employee. The employee has the right to review his/her personnel file upon request. The employee also has the right to an interview by his/her supervisor when requested.

The member facility should provide malpractice coverage to its employees while performing their jobs. Each facility must support Affirmative Action Practices in staffing and advertising positions.

There must be a written and posted protocol for life-threatening medical emergencies. In addition, there must be written descriptions of procedures and policies in each area of care including:

nursing

counseling

abortion procedures

laboratory services.

It is recommended that clinic hours be set considering the needs of the patients as well as the staff.

Clinic Security

Written guidelines must be available for all staff relating to non-medical emergency procedures. These should be posted in a place appropriate for inspection by staff members.

It is recommended that a smoke and burglar alarm system be installed in each facility.

Patient Fees and Records

Each facility should be morally obliged to have policies to accomodate low-income women. Specific financial arrangements should be made available to a minimum of 10% of the patient load.

There must be a contractual agreement between the woman and the facility outlining the payment plan and the collection policies. Collection policies must be in compliance with federal guidelines. The patient's record must not be released without the consent (preferably in writing) of the patient.

Confidentiality

Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. Since most states do not have legislation protecting the confidentiality of medical records, care must be taken when making notation on her record (particularly counseling notes). In addition, if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit the release of

the records without the woman's consent.

Additional suggestions to protect confidentiality:

* Keep all doors locked in accordance with fire code except the door where the patients enter.

* Shred all waste paper that may have a patient's name or information before discarding.

* Lock all information with patient's names, including appointment books and daily logs each night.

* Keep any and all paper work with identifying names and numbers in desks - not unattended in full view of others in the clinic.

* Never disclose information about a patient that may be in the facility to a telephone caller; rather state that if that person is in the facility, she can

call the person back, and have them leave a number.

Minors

Minors should be served in the same manner as other women, keeping in mind possible restrictions upon hospital admissions without parental consent. If hospitals will not admit without parental consent, minors should be made aware that, in case of emergency, it may not be possible to maintain confidentiality.

Administrative Supervision

While direct professional supervision of physicians, nurses, and counselors is the responsibility of the senior professional in each area, the chief administrative officer responsible for the general supervision of clinic functions must assure that personnel policies and

procedures are formulated, distributed, and observed in an equitable manner.

In a professional organization such as an abortion service, this includes the arrangements for continuing training in the form of individual supervision, in-service education programs, and continuing education opportunities for all professional and paraprofessional staff members.

Individual agencies are responsible for knowledge of current local nurse practice acts. Agencies may not require nurses to practice outside the legal limits of local nurse practice acts.

Agencies are also responsible for knowledge of the current state of licensure and professional liability insurance for physicians engaged in medical practice within the facility or

those acting in its name.

REPORTING STANDARDS

The maintenance of complete and accurate records is important for quality patient care and meaningful review of services. Reporting of legally induced abortions to public agencies where required and to non-public agencies is essential for providing and improving maternal health and family planning services. Confidentiality of individual patient identity is essential and must be safeguarded in abortion reporting.

In order to provide a uniform basis for evaluation of abortion services, the National Abortion Federation requests each participating institution to provide the following data on a quarterly basis:

* the number of abortions performed;
* length of gestation;
* the percentage of patient followup

contact made within six weeks of the abortion;

* the number of deaths;

* the number of patients receiving one or more blood transfusion;

* perforation, known or suspected;

* the number of patients experiencing pelvic infection requiring hospitalization of at least 72 hours within two weeks of the abortion;

* the number of repeat abortion procedures because of retention of tissue within one month of the original procedure.

Data from individual institutions will be treated confidentially. The aggregate data will be analyzed and made available to participants. This data collection is distinguished from abortion reporting required by state or local

health departments.

REFERRAL STANDARDS

NAF member institutions which provide referral for abortion services are required to observe the following standards:

* Referrals must be limited to qualified physicians and services that maintain high standards. Those providing referral services must investigate and evaluate periodically the facilities to which they refer. Referral must be made to abortion facilities which have received an on-site inspection by either the referring agency or some other agency whose report is available.

* Whenever facilities are available, the woman should be offered an examination to establish the diagnosis and stage of pregnancy prior to referral.

* The state of health of the woman,

as well as the length of gestation, should be factors in determining the recommended choice(s) of the physician or service for referral.

* The facility providing the abortion service has a responsibility to report back, with the woman's consent, to the referring agency.

* No provider shall own or participate in a captive referral agency either proprietary or non-profit, that is not clearly identified to the consumer as affiliated with the provider service in question.

* Women must pay the fee for services to the agency rendering the service. If a referral agency offers counseling or aftercare services or charges a fee for referral, they must do so directly. Abortion facilities may not use referral

agencies to collect fees for abortion and related services. This does not include situations where contracts for third party payment for public-assistance patients are required for reimbursement.

AUG 4 1982

Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE ON BEHALF OF NATIONAL ORGANIZATION FOR WOMEN; NATIONAL ABORTION RIGHTS ACTION LEAGUE; NORTHWEST WOMEN'S LAW CENTER; WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

PHYLLIS N. SEGAL
JUDITH I. AVNER
(Counsel of Record)
ANNE E. SIMON
NOW Legal Defense and Education Fund
132 West 43 Street
New York, New York 10036

JEMERA RONE
919 Third Avenue
New York, New York 10022

Attorneys for Amici Curiae

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
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—v.—

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Plaintiffs-Respondents.

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1982

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Chris Simopoulos, M.D., FACOG,
Appellant,
v.
Commonwealth of Virginia,
Appellee.

Nos. 81-746 and 81-1172
City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive
Health, Inc., et. al.,
Plaintiffs-Respondents.

Akron Center for Reproductive
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Plaintiffs-Petitioners,
v.
City of Akron, et al.,
Defendants-Respondents.

Nos. 81-1225 and 81-1623

Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Petitioners,
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents.

John L. Ashcroft, Attorney General
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ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE, AND WOMEN'S LAW PROJECT

The National Organization for Women, National Abortion Rights Action League, Northwest Women's Law Center, Women and Health Roundtable and Women's Law Project respectfully move, pursuant to Rule 36.3 of this Court's Rules, for leave to file the attached brief amici curiae. Counsel for Appellant Chris Simopoulos, Petitioner City of Akron, Respondent Akron Center for Reproductive Health, Petitioner Ashcroft and Respondent Planned Parenthood Association of Kansas City have consented to the filing of this brief and their letters of consent

have been filed with the Clerk. The Commonwealth of Virginia has refused consent.

The NATIONAL ORGANIZATION FOR WOMEN is a national membership organization of 170,000 women and men in over 750 chapters throughout the country. NOW has as one of its priorities, the preservation of the right to reproductive freedom, including abortion. NOW believes that every woman has a fundamental constitutional right to decide whether to terminate her pregnancy by abortion. NOW submits that the restrictions challenged herein impermissibly impinge upon this constitutionally protected right.

The NATIONAL ABORTION RIGHTS ACTION LEAGUE is dedicated to keeping abortion legal, safe and available. It has more than 150,000 national members plus af-

filiates with their own membership drawn from the pro-choice majority throughout the country.

The NORTHWEST WOMEN'S LAW CENTER is a non-profit public interest law organization dedicated to securing equal rights for women through law. Located in Seattle, the Law Center conducts community and continuing legal education programs throughout the Northwest on women's legal rights; offers information and referral, and advice and counseling services; and provides legal representation or assistance in selected cases that will impart the laws and legal rights of large numbers of women.

The WOMEN AND HEALTH ROUNDTABLE, a project of the Federation of Organizations for Professional Women, is an association of organizations and indi-

viduals concerned with women's health issues and policy. Through a series of publications and forums during its five year history, the Roundtable has monitored public health policy and analyzed its implications for women. The Roundtable is concerned that policies such as those before this Court, would infringe on a woman's constitutionally protected right to choose to terminate her pregnancy.

The WOMEN's LAW PROJECT is a non-profit public interest law firm working since 1973 to challenge sex discrimination in the law and in legal and social institutions.

Amici are womens' rights organizations whose constituencies and interests are seriously affected by the decisions in these cases. At issue is the consti-

tutionality of governmentally created obstacles to the exercise of a woman's constitutionally protected right to decide whether to terminate a pregnancy. Amici request leave to file this brief because of the extraordinary importance of these cases to the lives of women and children. Amici believe that their brief will elaborate for the Court the grave impact on individuals of the government restrictions challenged herein.

Respectfully submitted,

Phyllis N. Segal
Judith I. Avner
(Counsel of Record)
Anne E. Simon

NOW Legal Defense
and Education Fund
132 West 43 Street
New York, N.Y. 10036

Jemera Rone
919 Third Avenue
New York, N.Y.

Attorneys for Amici Curiae

TABLE OF CONTENTS

Page

Table of Authorities v

Interest of Amici. 2

Introductory Statement and Summary. 2

Argument 7

I. The Challenged Regulations Seriously Restrict — and in Some Instances Effectively Eliminate the Fundamental Right of a Woman to Decide Whether or Not to Terminate Her Pregnancy. 7

A. For Many Women, the Challenged Regulatory Schemes Effectively Eliminate the Right to Decide to Terminate a Pregnancy. 11

B. Where the Challenged Restrictions Do Not Totally Eliminate The Right of a Woman To Decide To Terminate A Pregnancy, They

Page

Unduly Burden Her Exercise of This Constitutionally Protected Right. 16

1. The mandatory waiting period and the hospitalization requirement operate to cause unnecessary and health endangering delays in the performance of abortions.. 17

2. The controlled consent and attendant physician counseling requirements interfere with medical judgments about a woman's care and have a direct, detrimental impact on a woman's health. . . . 24

3. The challenged restrictions increase the financial and emotional costs for the woman deciding to terminate her pregnancy. 31

II. The Challenged Restrictions Do Not Withstand Constitutional Scrutiny . . . 37

Page

A. Strict Scrutiny Is Required Where, As Here, The Challenged Restrictions Burden A Woman's Exercise Of Her Fundamental Right To Terminate Her Pregnancy. 37

B. The Challenged Restrictions Cannot Withstand Strict Scrutiny And Are Invalid. 40

1. The second trimester hospitalization requirement is not reasonably related to the state's legitimate interest in protecting the woman's health.. 40

2. The mandatory consent, attending physician counseling and waiting period restrictions constitute unjustified state interference in the exercise of a fundamental right and are unconstitutional.. . . 49

a. The challenged restrictions are wholly impermissible when applied in the first

Page

trimester of pregnancy.. 49

b. The challenged restrictions do not advance a compelling state interest when applied after the first trimester of pregnancy.. 51

(1) The consent requirement. 51

(2) The attending physician counseling requirement. 56

(3) The mandatory waiting period requirement.. 58

Conclusion 60

TABLE OF AUTHORITIES

Cases	Page
Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981). . . .	5, 12, 19, 23, 25, 27, 31, 44, 56, 57
Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172 (W.D.Oh. 1979), aff'd in pertinent part, 651 F.2d 1198 (6th Cir. 1981). . . .	56, 57
Ashcroft v. Planned Parenthood Association Nos. 81-1225 and 81-1623.	3, 4
Bellotti v. Baird, 443 U.S. 662 (1979)	9, 16
Carey v. Population Services	

Cases	Page
International, 431 U.S. 678 (1977)	7
Charles v. Carey, 627 F.2d 772 (7th Cir. 1980).	19, 27, 28, 30, 51, 57, 59
City of Akron v. Akron Center for Reproductive Health, Inc., Nos. 81-746 and 81-1172.	4
Colautti v. Franklin, 434 U.S. 379 (1979). . . .	42
Doe v. Bolton, 410 U.S. 179 (1973)	8, 9, 43, 49
Eisenstadt v. Baird, 405 U.S. 438 (1972). . . .	7
Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978), aff'd, 440 U.S. 941	

Cases	Page
(1979)	52, 53
Griswold v. Connecticut, 381 U.S. 479 (1965)	7
Harris v. McRae, 448 U.S. 297 (1981)	10, 34, 40
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McRae v. Califano, 491 F. Supp. 630 (E.D.N.Y. 1980).	23, 24, 33
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Cases	Page
Planned Parenthood Association v. Ashcroft, 655 F.2d 848 (8th Cir. 1981)	4, 13, 22, 27, 29, 42, 46, 55, 59
Planned Parenthood Association v. Ashcroft, 483 F. Supp. 679 (W.D. Mo. 1980), aff'd in pertinent part, 655 F.2d 848 (8th Cir. 1981).	22
Planned Parenthood Association v. Ashcroft, No. 79-4142, slip op. (W.D. Mo. Oct. 2, 1981), aff'd, 664 F.2d 687 (8th Cir. 1981). . . .	12, 13, 31, 32
Planned Parenthood Association	

Cases	Page
v. Ashcroft, 664 F.2d 687 (8th Cir. 1981). . . .	13, 44
Planned Parenthood League v. Bellotti, 641 F.2d 1006 (1st Cir. 1981)	19, 20, 28, 29, 54, 59
Planned Parenthood v. Danforth, 428 U.S. 52 (1976)	9, 10, 16, 27, 28, 37, 42, 48, 49, 52,53, 56, 57
Poe v. Department of Public Health, No. 78 C 4126, slip op. (N.D. Ill. May 11, 1981).	42
Roe v. Wade, 410 U.S. 113 (1973)	8, 23, 24, 33, 38, 40, 49, 50, 51, 53, 57
Simopoulos v. Commonwealth of	

Cases	Page
Virginia, No. 81-185	2, 3
Simopoulos v. Commonwealth of Virginia, 221 Va. 1059, (Sup. Ct. 1981); 277 S.E.2d 194.	3, 13, 44
Singleton v. Wulff, 428 U.S. 106 (1976)	34
Whalen v. Roe, 429 U.S. 589 (1977)	27
Wolfe v. Stumbo, 519 F. Supp. 22 (W.D. Ky. 1980). . . .	42, 46
Women's Community Health Centers, Inc. v. Cohen, 477 F. Supp. 542 (D. Me. 1979).	18, 22, 51
Women's Medical Center of	

Cases — Page

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Page

(1973) 15

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§ 26-1202(b)
(1973) 15

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Stat. § 453-16(a)(2)
(1970) 15

Idaho Code
Ann. 18-608.2 (1973) . 15

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Sec. 18-24, Ill. Rev.
Stat. ch. 111 1/2,
§ 84 and Rules 12.6
and 12.61 (1977) . . . 15

Ind. Code
35.1-58.5(b)(2)
(1974) 15

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§ 311.760(2) (1974). . 15

La. Rev. Stat. Ann.
§ 1299.35.3 (West
1981). 15

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ch. 112, § 12N(2)(West
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R.325.3851 (1979). . . 15

Page

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§ 188.025
(Vernon 1978). 15

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(1974) 15

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Admin. Code, tit. 13
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11.05 (1978).. 15

Page

Legislative Materials

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Page

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Page

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In the
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No. 81-185

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ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

BRIEF AMICI CURIAE OF THE NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

INTEREST OF AMICI

The interest of amici appears in the foregoing motion.

INTRODUCTORY STATEMENT AND SUMMARY

These three cases involve attempts by state and local governments to restrict the opportunity of a woman to exercise her constitutionally protected decision to terminate her pregnancy. In Simopoulos v. Commonwealth of Virginia, No. 81-

185, the constitutionality of a Virginia statute that requires, inter alia, that all post-first trimester abortions be performed in hospitals is being challenged by a physician convicted of violating this law. He is appealing from the Virginia Supreme Court's affirmance of his conviction. 221 Va. 1059; 277 S.E.2d 194 (1981).[1] A Missouri statute similarly requiring that all abortions after the first trimester of a pregnancy be performed in hospitals is at issue in Ashcroft v. Planned Parenthood Association of Kansas City, Nos. 81-1225 and

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[1] Other issues raised by Dr. Simopoulos on appeal include whether the burden of proof imposed on him was improper and whether the prosecution failed to produce evidence necessary for conviction. These issues of due process and fairness in criminal proceedings, although important, are outside the specific interests of amici and are not addressed herein.

81-1623. The Eighth Circuit upheld the constitutionality of this provision, 655 F.2d 848 (8th Cir. 1981).[2]

City of Akron v. Akron Center for Reproductive Health, Nos. 81-746 and 81-1172, involves a challenge to the constitutionality of an Akron, Ohio ordinance that imposes an in-hospital requirement similar to those in the Virginia and Missouri laws. In addition, the Akron ordinance requires that a woman seeking an abortion be counseled by the attending physician; that she be

---

[2] Also presented for review are requirements that: minors obtain judicial authorization or parental consent for an abortion; a pathology report be submitted for every abortion; two physicians be present at all second trimester abortions. All but the first of these provisions were struck down by the Eighth Circuit. Although amici believe that all three of these provisions are invalid, they will not address them further herein.

told specified information before she consents to an abortion; and that she wait 24 hours after she consents before obtaining an abortion. The Sixth Circuit upheld the in-hospital requirement, but declared the counseling, consent and waiting period provisions unconstitutional, 651 F.2d 1198 (6th Cir. 1981).[3]

These statutory schemes all have the effect of burdening the procreative decisions of women. Amici believe that individuals have the constitutionally protected right to make such decisions

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[3] Other provisions of the Akron ordinance presented for review in this Court are requirements that all minors seeking abortions notify at least one parent and, if the minor is under 15 years of age, obtain the consent of at least one parent; and that the fetus be disposed of in a "humane" manner. These provisions were struck down by the Sixth Circuit. Amici believe that the Sixth Circuit's decision should be affirmed, but will not address these issues further herein.

free from government interference. In this brief, amici demonstrate the serious restrictive impact of certain of the legislative enactments at issue in these cases. Although some of these provisions were upheld and some struck down by the lower courts, amici argue that none of these restrictions can survive the strict judicial scrutiny mandated by this Court's precedents, and all should be invalidated.

ARGUMENT

I.

THE CHALLENGED REGULATIONS SERIOUSLY RESTRICT — AND IN SOME INSTANCES EFFECTIVELY ELIMINATE — THE FUNDAMENTAL RIGHT OF A WOMAN TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY

The right of every individual to be free from governmental interference in the exercise of personal procreative decisions has long been recognized as a fundamental liberty protected by the United States Constitution. See, e.g., Carey v. Population Services International, 431 U.S. 678 (1977); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965). This Court has made clear that the constitutional right to privacy is "broad

enough to encompass a woman's decision whether or not to terminate her pregnancy." Roe v. Wade, 410 U.S. 113, 153 (1973). This right to reproductive choice "protects the woman from unduly burdensome interference with her freedom to decide to terminate her pregnancy." Maher v. Roe, 432 U.S. 464, 473-74 (1977).

Consistent with these principles, the Court has invalidated government imposed restrictions that run afoul of this constitutional standard. In Doe v. Bolton, 410 U.S. 179 (1973), for example, a state law requiring that all abortions be approved in advance by a hospital abortion committee was held unconstitutional because the limitation

was "unduly restrictive of the patient's rights and needs." 410 U.S. at 198. In Planned Parenthood v. Danforth, 428 U.S. 52 (1976), spousal and parental consent requirements could not pass constitutional muster because the state did not have the authority to "give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy." 428 U.S. at 74. See also Bellotti v. Baird, 443 U.S. 662 (1979).

The limitations on abortions imposed by the challenged restrictions in the trilogy of cases now before the Court similarly attempt to circumscribe a woman's behavior and significantly im-

pair the exercise of her fundamental right to decide whether to bear a child. These restrictions cannot be dismissed as "not burdensome or chilling." Planned Parenthood v. Danforth, 428 U.S. at 66, citing 392 F. Supp. at 1374. Nor can they be characterized as merely "state encouragement of . . . childbirth," Maher v. Roe, 432 U.S. at 475, or described as placing "no obstacles in the pregnant woman's path to an abortion." 432 U.S. at 474. See also Harris v. McRae, 448 U.S. 297 (1981). The statutory schemes enacted by Missouri, Virginia and Akron, Ohio forcefully inject government into a constitutionally protected decision-making process, riding roughshod over individuals' most

private decisions. They are aimed at coercing a woman not to terminate her pregnancy by placing obstacles directly in her path.

A. For Many Women, The Challenged Regulatory Schemes Effectively Eliminate The Right To Decide To Terminate A Pregnancy

Although benign sounding on its face, the requirement that a second trimester abortion be performed in a hospital effectively eliminates, for many women, the ability to exercise their fundamental right to reproductive choice. In Missouri, Virginia and Akron, Ohio, as in many areas of this country, there are few, if any, hospitals that perform second trimester abortions. Regulations requiring that all second trimester abortions be performed in hospitals

effectively eliminate the right to decide to terminate a pregnancy when there are no hospitals to provide such medical care.

For example, unrebutted testimony in the Akron case revealed that there were only two hospitals in Akron performing second trimester abortions, and during 1977, only nine second trimester abortions were performed in these two hospitals. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981). Many Akron women seeking second trimester abortions were referred to clinics in Cleveland, Ohio and in the state of Michigan. 651 F.2d at 1209. In Planned Parenthood Association v. Ashcroft, No. 79-4142, slip op.

at 10 (W.D. Mo. Oct. 2, 1981), aff'd, 664 F.2d 687 (8th Cir. 1981), the district court concluded that the effect of Missouri's in-hospital requirement was to render unavailable a common method of second trimester abortions in the state.[4] Similarly, testimony in Simopoulos v. Commonwealth of Virginia, 221 Va. 1059, 277 S.E.2d 194 (Sup. Ct. 1981), demonstrated that only two hospitals in Northern Virginia performed second trimester abortions.

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[4] On remand from the Eighth Circuit Court of Appeals in Planned Parenthood Ass'n v. Ashcroft, 655 F.2d 848 (8th Cir. 1981), the district court found that the in-hospital requirement in Missouri did in fact result in the performance of fewer second trimester abortions. Planned Parenthood Ass'n v. Ashcroft, No. 79-4142, slip op. at 9. The district court there had the benefit of reviewing expert testimony comparing the incidence of abortions in Missouri in two recent consecutive years, one without and one with the in-hospital requirement. Id. at 9 n.14 & 15 and text.

Nor is this picture unique to Missouri, Virginia or Akron, Ohio. In Louisiana, for example, no hospitals perform abortions after the first trimester. Margaret S. v. Edwards, 488 F. Supp. 181, 192 (E.D. La. 1980). A recent national survey indicated that less than one-third of all hospitals in the United States perform abortions after the first trimester.[5] Henshaw, Forrest, Sullivan, Tietze, "Abortion Services in the United States, 1979 and 1980," 14 FAM. PLAN. PERSP. Jan.-Feb. 1982, at 5 (1982) [hereinafter cited as "Henshaw"].

Where hospitals are unavailable to perform a second trimester abortion, a

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[5] Even where hospital facilities are available, the increased financial cost may put the abortion beyond the reach of many women. See discussion infra.

government imposed hospitalization requirement essentially acts as a governmental veto of a woman's decision to seek an abortion.[6] It operates as the kind of unauthorized, arbitrary governmental usurpation of a woman's constitutionally guaranteed right to decide to

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[6] Despite this dramatic unavailability of hospital facilities, twenty-one states have acted to require hospitalization for second trimester abortions. Conn. Agencies Regs.§ 19-13-D54 (1973); Ga. Code Ann. § 26-1202(b) (1973); Hawaii Rev. Stat. § 453-16(a)(2) (1970); Idaho Code Ann. 18-608.2 (1973); Abortion Law of 1975, Sec. 18-24, Ill. Rev. Stat. ch. 111 1/2, § 84 and Rules 12.6 and 12.61 (1977); Ind. Code 35.1-58.5(b)(2) (1974); Ky. Rev. Stat. § 311.760(2) (1974); La. Rev. Stat. Ann. § 1299.35.3 (West 1981); Mass. Gen. Laws Ann. ch. 112, § 12N(2)(West 1974); Mich. Admin. Code R.325.3851 (1979); Mo. Ann. Stat. § 188.025 (Vernon 1978); Mont. Code Ann. § 94-5-618 (1974); Nev. Rev. Stat. 442.250.2 (1981); N.J. Admin. Code, tit. 13 § 13, § 35-7.2 (1978); N.Y. Pub. Health Law § 4164 (1974); N.D. Cent. Code ch. 14-02:1-04.2 (1981); Okla. Stat. tit. 63 § 1-731.B (1978); Tenn. Code Ann. § 39-301(e) (1981); Utah Code Ann. § 76-7-302(2) (1974); Va. Code § 18.2-73 (1975); Wis. Admin. Code, § Chap. Med. 11.05 (1978).

terminate her pregnancy, consistently condemned by this Court. Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 443 U.S. 622 (1979).

B. Where The Challenged Restrictions Do Not Totally Eliminate The Right of a Woman To Decide To Terminate a Pregnancy, They Unduly Burden Her Exercise of This Constitutionally Protected Right

Those challenged provisions that do not operate to totally eliminate the ability of a woman to decide to terminate her pregnancy nonetheless erect significant obstacles to the exercise of her right by imposing a mandatory waiting period, requiring attending physician counseling and establishing controlled consent procedures. This is also the consequence of the hospitaliza-

tion requirement in those areas where hospital facilities exist but are totally inadequate. These restrictions cause unnecessary delays in the performance of abortions; jeopardize the health of women who decide to terminate a pregnancy; and subtantially increase the financial costs of abortion, thereby limiting the ability of many women to undergo a safe, legal abortion procedure. They represent deliberate governmental intrusion into the constitutionally protected realm of personal decision-making.

1. The mandatory waiting period and the hospitalization requirements operate to cause unnecessary and health endangering delays in the performance of abortions.

Although advanced as a benevolent "cooling off" period, the mandatory

waiting period required by the Akron ordinance injects the government directly into the personal decision-making process reserved to the woman and her physician. The decision to seek an abortion is made after extensive consultation and consideration. See Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. 542, 551 (D. Me. 1979). It is not made precipitously or irresponsibly as the language of the challenged legislation might have one think. Yet, once the decision has been reached, the mandatory waiting period temporarily forecloses the availability of an abortion. It is "direct state interference" with a woman's abortion decision. Maher v. Roe, 432 U.S. at 473-75, quoted in

Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981).

Although the Akron restriction challenged herein explicitly imposes a 24-hour delay between the time a woman signs the consent form and undergoes the abortion, in reality the delay it causes will be far greater. The evidence in Akron showed that no city clinic performed abortions more than three times a week. Thus, a 24-hour waiting period may actually mean a minimum delay of two to four days. 651 F.2d at 1201. See also Planned Parenthood League v. Bellotti, 641 F.2d at 1014; Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980). Especially for women who must travel to the abortion facility, this

extended delay can be a severe hardship. Such a scheme necessarily imposes

> burdens in terms of time, money, travel and work schedules; for many women, particularly the poor, the rural, and those with pressing obligations, these burdens will be substantial.

Planned Parenthood League v. Bellotti, 641 F.2d at 1015.

In addition, the second trimester hospitalization requirement, where not an insuperable barrier, similarly causes for many women a significant delay in obtaining medical care. As discussed at Point I, supra, hospital facilities are unavailable in many places, and where available, at best are inadequate. As a result, even where a facility can be found, travel time and the time it takes

to make appropriate arrangements (e.g., locating the hospital; scheduling hospital space availability; accommodating the woman's family and employment responsibilities) frequently result in delaying performance of the abortion. Donovan, "Analysis: Courts Rejecting 'Maternal Health' Rationale for Hospitalization for All Mid-Trimester Abortions," 9 FAM. PLAN./POPULATION REP. Dec. 1980, at 91 (1980) [hereinafter referred to as "Donovan"]. The adverse impact of travel necessitated by hospitalization requirements and the significant burden thereby imposed results in a significant relationship between a woman's distance from an abortion facility and the likelihood that she will obtain

an abortion. Margaret S. v. Edwards, 488 F. Supp. at 193-94 nn. 33 & 39.

As with any medical procedure, delay operates to increase the medical risk. The earlier in the pregnancy an abortion is performed, the lower the risk of complications or death. Courts have recognized that any risk to the woman presented by the abortion procedure increases the later the abortion is performed, affecting both her mental and physical health. See e.g., Planned Parenthood Association v. Ashcroft, 483 F. Supp. 679, 696 (W.D. Mo. 1980), aff'd in pertinent part, 655 F.2d at 866; Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. at 551. Even a delay of two to seven days can pose a

major health risk to women undergoing abortions. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. I, 70, 82; III, 167-68).[7]

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[7] Expert testimony presented to the trial court in Akron indicated that generally, every week of delay beyond eight weeks' gestation increases the risk of morbidity by 20% and of mortality by 50%. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. IV, 156-57).

These serious consequences of delay must, however, be viewed in the context of the overall risks associated with pregnancy, childbirth, and abortion. All pregnancies pose health risks. These risks range from injury from falls occasioned by the unusual weight distribution of advancing pregnancy to death from hemorrhage, pulmonary embolism and toxemia, among other causes. McRae v. Califano, 491 F. Supp. 630, 668-71 (E.D.N.Y. 1980). The health problem is particularly acute for indigent pregnant teenagers, who suffer from higher maternal mortality rates and are more likely to suffer health complications from pregnancy. See McRae v. Califano, 491 F. Supp. at 680-81; Alan Guttmacher Institute, 11 Million Teenagers 23 (1976).

In fact, the risk of death from childbirth is significantly greater than the risk of death from abortion. The Court in Roe v. Wade, 410 U.S. 113 (1973), cited medical data as evidence that maternal mortality rates for early abortions "appear to

(Footnote continued)

Thus, by causing delays in the abortion procedure the challenged restrictions force women to jeopardize their health.

2. The controlled consent and attending physician counseling requirements interfere with medical judgments about a woman's care and have a direct, detrimental impact on a woman's health.

By intruding directly into the decision-making process at a critical time, the controlled consent and attending physician counseling requirements of the Akron ordinance are aimed at influ-

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be as low as or lower than the rates for normal childbirth" and concluded that in early abortion, "maternal mortality in abortion may be less than mortality in normal childbirth." Id. at 149, 163 (emphasis added). More recent statistics make clear that abortion is substantially safer than childbirth. McRae v. Califano, 491 F. Supp. at 65. Mortality in childbirth for white women in 1974 was 10 per 100,000 live births; mortality in abortion was 0.5. For "black and other" women, mortality in childbirth was 35.1 per 100,000 live births; in abortion, 2.4. Id.

encing the woman to continue her pregnancy. The government seeks to do this regardless of the woman's own decision-making choices, and heedless of the fact that the pregnancy may be life endangering or health-threatening.

The consent restriction challenged in Akron prescribes a script to be read, word-for-word, by the attending physician.[8] The provisions substitute the

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[8] In pertinent part, the ordinance requires the physician to tell a woman:

> (3) [t]hat the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external

(Footnote continued)

legislature's medical judgment for that of the attending physician. Not only does this straitjacket the physician's exercise of medical judgment, but its effect is to encumber the exercise of

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members;

(4) [t]hat her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion;

(5) [t]hat abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

AKRON, OH., ORDINANCE No. 160 § 1870.06B(3),(4),(5) (1978).

the woman's constitutionally protected right "by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice ...." Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), quoted in Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1207. See Planned Parenthood v. Danforth, 429 U.S. 52 (1976).

The challenged restriction requires the woman to be "informed" of "facts" that are incorrect,[9] prejudi-

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[9] See Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 868 (physicians' testimony that they do not believe there are long-term physical and psychological effects of abortion); Charles v. Carey, 627 F.2d at 784 (medical testimony characterizing possibility of "organic pain" to fetus as "medically meaningless, confusing, [and] medically unjustified"); Leigh v. Olson, 497 F. Supp. 1340, 1345 (D.N.D. 1980) (medical experts dispute validity of statement that abortion increases the risks of sterility, premature births, tubal pregnancies and still births in future pregnancies); Wynn v. Scott,

(Footnote continued)

cial[10] and irrelevant.[11] Rather than provide necessary information, the restrictions are calculated to inflict emotional distress, anxiety or physical

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449 F. Supp. 1302, 1317 (N.D. Ill. 1978) (studies have not supported statement that there is danger of subsequent sterility).

[10] See Planned Parenthood League v. Bellotti, 641 F.2d at 1021 (fetal descriptions and information on medical complications would cause many women emotional distress, anxiety, guilt or physical pain which might influence the decision, especially for those who were rape victims or who carried a potentially deformed fetus); Charles v. Carey, 627 F.2d at 784 (mandatory information was found to cause "cruel and harmful stress to . . . patients"). See also Planned Parenthood League v. Bellotti, 641 F.2d at 1022 (purpose of required information more moral than factual; "[t]he state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights").

[11] See Planned Parenthood v. Danforth, 428 U.S. at 67 n.8 (consent requirement limited to "the giving of information . . . as to just what would be done and as to its consequences"); Planned Parenthood League v. Bellotti, 641 F.2d at 1021-23 (information must be material to medically relevant considerations).

trauma.[12] Planned Parenthood League v. Bellotti, 641 F.2d at 1021; Leigh v. Olson, 497 F. Supp. at 1345. Indeed, in addition to believing that some of the required information is detrimental to the best health interests of their patients, medical experts assert that the risks from abortion may be increased due to the woman's heightened tension and anxiety. Planned Parenthood Association v. Ashcroft, 655 F.2d at 868.

The Akron ordinance makes no exception, but inflicts the punitive "required reading" on all women, far surpassing any conceivable interest the

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[12] E.g., the majority of women would not want to hear fetal descriptions prior to an abortion and most doctors would not consider it good medical practice to provide them. Planned Parenthood League v. Bellotti, 641 F.2d at 1022.

state may have in assuring that the decision is knowingly made. See Charles v. Carey, 627 F.2d at 784.

Denominating the attending physician as the one who must provide the prescribed "information" similarly ignores the health needs of the woman. This requirement forces the physician to provide the information even though, in his or her professional judgment, a trained counselor would be much more effective in imparting certain information and obtaining consent. Women's Medical Center of Providence, Inc. v. Roberts, 530 F. Supp. 1136, 1147-48 (D.R.I. 1982); see Leigh v. Olson, 497 F. Supp. at 1346. It denies the physician this flexibility and may deprive

the woman of critically important support at an emotionally trying time.

3. The challenged restrictions increase the financial and emotional costs for the woman deciding to terminate her pregnancy.

The challenged restrictions further burden the exercise of the constitutional right to reproductive decision-making by unnecessarily increasing the financial costs of such medical care. The cost of having a second trimester abortion performed in a hospital on an inpatient basis is not insubstantial. It has been found to be at least twice the cost of the same procedure performed in an outpatient clinic. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parent-

hood Association v. Ashcroft, slip op. at 7 n.9,11 and text (W.D. Mo. Oct. 2, 1981); Donovan, 91.[13]

The travel frequently required to comply with hospitalization requirements and mandatory waiting periods imposes an additional significant economic burden on the abortion decision because of the expenses incurred for transportation, lodging and child care, as well as because of the loss of income due to the additional time required. These economic impediments to the decision to end a pregnancy by abortion are particularly critical in light of federal and state

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[13] On remand in Ashcroft, the district court found that the additional expense of having a second trimester abortion performed in a hospital as compared to a clinic, ranged from $150 to $1,650. Planned Parenthood Ass'n v. Ashcroft, slip op. at 7 n.9 and text (W.D. Mo. Oct. 2, 1981).

restrictions on the public funding of abortions.[14]

Although the Court has recognized that a woman's fundamental interest in personal privacy protects her choice of whether to continue or to terminate her pregnancy, Roe v. Wade, 410 U.S. 113 (1973), in reality, only those women able to pay the cost of their medical care can effectuate their constitutional choice between these two alternatives

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[14] Indeed the federal government has acted to deny funds for almost all abortions precisely because it wishes to subvert the reproductive choice of women seeking to terminate their pregnancies. For example, the chief sponsor of the funding restriction, Rep. Henry Hyde, declared his intention "to forbid the use of Federal funds to promote or encourage anyone to have an abortion," 122 CONG. R. H26784 (daily ed. August 10, 1976) (statement of Rep. Hyde). See also McRae v. Califano, 491 F. Supp. 630, 640-46 (E.D.N.Y. 1980).

free from state interference.[15] Where the physician cannot afford to work for no fee, and the woman cannot afford to pay, safe medical abortion is not a realistic alternative. See Singleton v. Wulff, 428 U.S. 106, 118-19 n.7 (1976). Governmental regulations designed to unnecessarily increase the cost of abortions, combined with virtual elimination of public funding, undoubtedly will have the intended effect upon many women: lacking feasible alternatives they will be forced to continue their unwanted pregnancies. And, for some, this will mean the unwilling continuation of a

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[15] As the Court recognized in Maher v. Roe, 432 U.S. 464, 474 (1977), by funding the childbirth alternative for the Medicaid-dependent woman and excluding the abortion alternative, the state deliberately influences the woman's reproductive choice. See Harris v. McRae, 448 U.S. 297 (1980).

life-endangering or health threatening pregnancy. The merger of increased regulation and decreased funding will have an additional, critical effect: emotionally distraught and unable to raise the money for a legal abortion, some women will turn in desperation to less costly and less safe illegal abortions.[16] The most recent statistics available show that in 1977, for the first time since 1972, reported deaths due to illegal abortions increased.[17]

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[16] U.S. Dep't of Health, Education and Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1977 12-14 (1979).

[17] Id. at 1. See Petitti and Cates, "Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age," 67 Am. J. Pub. Health 860, 861 (1977).

Still other women will risk their lives by attempting one of the numerous dangerous methods of self-abortion.[18]

Thus, the increased emotional, health and financial costs resulting from the challenged restrictions impermissibly jeopardize and burden the health and well-being of women.

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[18] "Among the non-medical procedures used for inducing abortion," according to the National Academy of Sciences Institute of Medicine, "are eating or drinking quinine or other drugs, introduction of chemicals into the vagina, and mechanical methods such as inserting blunt or sharp instruments into the uterus through the vagina. The drugs quite often lead to poisoning or vomiting so intense that it results in dehydration and eventual death unless fluid replacement compensates the loss. Inserting chemicals or instruments in the vagina or uterus can lead to: (1) infection; (2) injury to the membranes of the vagina; (3) perforation of the uterus with the possibility of injury to other organs in the abdominal area; (4) bleeding due to retained fetal or placental tissue; and (5) air embolism." National Academy of Sciences Institute of Medicine, Legalized Abortion and Public Health 64 (1975).

II

THE CHALLENGED RESTRICTIONS DO NOT WITHSTAND CONSTITUTIONAL SCRUTINY

A. Strict Scrutiny Is Required Where, As Here, The Challenged Restrictions Burden A Woman's Exercise Of Her Fundamental Right To Terminate Her Pregnancy

This Court has repeatedly held that a statutory scheme which infringes upon a woman's fundamental right to decide to terminate her pregnancy by abortion can survive constitutional scrutiny only if justified by a compelling state interest that is narrowly drawn to express the legitimate state interests at stake.[19]

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[19] The strict scrutiny standard is called into play if two conditions exist. First, the obstacle to the exercise of the fundamental right must have been created by the government. Maher v. Roe, 432 U.S. 464 (1977). Second, the restriction must impinge upon the exercise of the fundamental right. Planned Parenthood v. Dan-

(Footnote continued)

Roe v. Wade, 410 U.S. at 155. The Court in Roe accepted the assertion by the State of Texas that there are legitimate state interests during the pregnancy in the health of the woman and in protection of potential fetal life.[20] Finding these interests to be separate and distinct, and conflicting with the woman's right to decide to terminate a pregnan-

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forth, 428 U.S. 52 (1976). Since both conditions are present, the obstacle created by the Missouri, Virginia and Akron, Ohio legislation can stand only if justified by a compelling state interest narrowly drawn. Roe v. Wade, 410 U.S. 113 (1973).

[20] This Court declined to define the point at which life begins. "When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." Roe v. Wade, 410 U.S. at 159. The Court rejected the attempt of Texas to define "life" as beginning at conception and thus to justify state interference throughout the pregnancy.

cy, the Court divided pregnancy into trimesters, defining the legitimate state interest, and therefore the parameters of state interference, at each juncture.

During the first trimester of pregnancy, neither the state's interest in the woman's health nor in potential fetal life can justify any state interference with the woman's right to decide. In the second trimester, state intrusion is permissible only if it promotes the state's legitimate interest in ensuring the woman's health. And in the third trimester, the state's interest in the potential life of the fetus is sufficient to justify significant intrusion, even a total proscription of

abortion, unless an abortion is necessary to preserve the life or health of the woman. See Roe v. Wade, 410 U.S. at 163-64; Harris v. McRae, 448 U.S. at 313. Thus, protecting the woman's health is the paramount state interest in the second and third trimesters of pregnancy. When measured against this interest, the challenged restrictions must fail, for they are nothing more than a thinly veiled attempt to limit the availability of abortions, in essence to accomplish through the back door what the Court forbade in Roe.

B. The Challenged Restrictions Cannot Withstand Strict Scrutiny And Are Invalid

1. The second trimester hospitalization requirement is not reasonably related to the state's legitimate interest in protecting the woman's health.

As discussed fully at Point I, supra, the requirement that all second trimester abortion procedures be performed in licensed hospital facilities has the effect of totally eliminating or significantly decreasing the availability of second trimester abortions. There can be no greater example of direct state interference infringing on the exercise of a fundamental right than denial of access to the means necessary to effectuate that right. Further, since these requirements drastically limit the availability of the two safest and most common methods of second trimester abortions,[21] the state's asserted interest

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[21] The techniques specifically addressed in these cases are the dilatation and evacuation and saline installation procedures. Recent medical studies demonstrate and courts have

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in protecting the woman's health is revealed to be not a justification, but a transparent excuse.

In view of the demonstrable burden placed on the abortion decision by requiring all second trimester abortions to be performed in hospitals, the state must show that such restriction promotes

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found, that D & E is now the most used and safest procedure for early second trimester abortions, Margaret S. v. Edwards, 486 F. Supp. at 195; Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 856; Wolfe v. Stumbo, 519 F. Supp. 22, 25 (W.D. Ky. 1980); see Poe v. Dep't of Public Health, No. 78 C 4126 slip. op. (N.D. Ill., May 11, 1981).

Use of the saline method was upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). In support of its holding, the Court found that saline is "an accepted medical procedure"; if utilized in a "substantial majority . . . of all post-first trimester abortions" it is "safer, with respect to maternal mortality, than even the continuation of the pregnancy until normal childbirth." 428 U.S. at 77, 78. See Colautti v. Franklin, 434 U.S. 379, 398-99 (1979).

its interest in the woman's health. To satisfy this constitutional burden, "the State must show . . . that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." Doe v. Bolton, 410 U.S. at 195.

The evidence submitted in each case before the Court does not support a conclusion that second trimester hospital abortions are significantly less dangerous to a woman's health than comparable procedures performed in non-hospital clinics. To the contrary, the records below amply demonstrate that the second trimester abortion methods used in these cases -- dilatation and evacua-

tion and saline instillation -- can safely be performed outside a hospital. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parenthood Association v. Ashcroft, 664 F.2d at 690 (8th Cir. 1981); Simopoulos v. Commonwealth of Virginia, 221 Va. at 1075-76, 277 S.E.2d at 202-03.

It is particularly significant that the American College of Obstetricians and Gynecologists, reversing an earlier position, has concluded that second trimester abortions may be safely performed in non-hospital facilities. See American College of Obstetricians and Gynecologists, Manual of Standards for Obstetrician Gynecological Services at

16 (1982). ACOG has made clear its approval of the performance of abortions on an outpatient basis through the 18th week from the last menstrual period. The American Public Health Association advises that "[r]equirements that all abortions after [the first trimester] be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure." Donovan at 91-92. Similarly, other medical experts have concluded that both procedures can be safely performed in non-hospital facilities. See Cates, Grimes, "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," 58 Obstetrics and Gynecology 401

(1981)[22]; Schulman, Kaiser, Randolph, "Outpatient Saline Abortion," 37 Obstetrics and Gynecology 521 (1971).

In view of the medical evidence demonstrating the safety of outpatient second trimester abortions, it is obvious that restrictions which require all second trimester abortions to be performed in hospitals are not reasonably related to the preservation of the woman's health, nor are they narrowly drawn to avoid overbroad interference with a woman's decision whether to bear a child. Planned Parenthood Association v. Ashcroft, 655 F.2d at 853-57; Wolfe v. Stumbo, 519 F. Supp. at 24-25; Marga-

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[22] These authors also suggest that policymakers reconsider laws requiring all second trimester abortions to be performed in hospitals.

ret S. v. Edwards, 488 F. Supp. at 194-96. Thus, there is no medical justification for the restriction.

Moreover, by imposing a hospitalization requirement, the state is deliberately endangering a woman's health. The hospitalization requirement operates to make second trimester abortions unavailable for many women, as discussed at Point I, supra, and adds the burden of time delays for many more. As discussed at Point I, supra, each day of delay increases the woman's health risk. This puts the state's restrictive action in a head-on collision with its acknowledged interest in protecting the woman's health. Far from serving the woman's health interest, the hospitalization

restriction actually endangers the woman's health by effectively "proscrib[ing] the safest alternative presently available for post-first trimester abortions." Margaret S. v. Edwards, 488 F. Supp. at 193. This result may, "as a practical matter . . . forc[e] a woman and her physician [to continue her pregnancy or] to terminate her pregnancy by methods more dangerous. . . ." Planned Parenthood v. Danforth, 428 U.S. at 79.

Therefore, this restriction is an "unreasonable [or] arbitrary regulation designed to inhibit and having the effect of inhibiting" the vast majority of abortions after the first trimester. Planned Parenthood v. Danforth, 428 U.S. at 79. Accordingly, it is a restriction

that plainly contravenes the constitutionally protected right of women seeking second trimester abortions, and this Court's holdings in Roe v. Wade, Doe v. Bolton and Planned Parenthood v. Danforth.

2. The mandatory consent, attending physician counseling and waiting period restrictions constitute unjustified state interference in the exercise of a fundamental right and are unconstitutional.

a. The challenged restrictions are wholly impermissible when applied in the first trimester of pregnancy.

Roe v. Wade makes clear that there can be no interference with the woman's decision-making process during the first trimester of a pregnancy. 410 U.S. at

163. The challenged consent, attending physician counseling and waiting period restrictions directly interfere with -- indeed disrupt -- the exercise of the constitutionally protected right to abortion. As fully discussed at Point I, supra, these limitations impose substantial burdens on the decision to terminate a pregnancy by abortion. The restrictions add the state as a third party in the decision-making process -- invisible but present, both through words which must be spoken by a state-designated individual and through a forced "cooling off" period. These direct intrusions into the decision to undergo a first trimester abortion are

flatly contrary to the clear mandate of Roe v. Wade, and cannot stand.[23]

b. The challenged restrictions do not advance a compelling state interest when applied after the first trimester of pregnancy.

(1) The consent requirement.

Rather than furthering communication between the physician and patient to enhance understanding of the medical procedure, the mandated consent requirement in the Akron ordinance is a transparent attempt to control the woman's decision whether or not to terminate her pregnancy. It is a far cry from the

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[23] Many lower courts have invalidated similar provisions. See, e.g., Charles v. Carey, 627 F.2d at 784-86; Women's Medical Center of Providence v. Roberts, 530 F. Supp. at 1144; Margaret S. v. Edwards, 488 F. Supp. at 212; Women's Community Health Center v. Cohen, 477 F. Supp. 542, 551-52.

consent requirement upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). There, the Court scrutinized and upheld a statutory restriction that required a woman, prior to obtaining a first trimester abortion, to certify in writing that her "consent is informed and freely given and is not the result of coercion." Id. at 65. "Informed consent" was construed in Danforth as:

> [T]he giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine an attending physician in an undeserved and uncomfortable straitjacket in the practice of his profession.

428 U.S. at 67 n.8; see Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978),

aff'd, 440 U.S. 941 (1979). The City of Akron has attempted to expand beyond recognition the exception carved out in Danforth -- building from this exception a scheme which would swallow the rule in Roe v. Wade.

The Akron restriction, unlike the provision in Danforth, dictates to the physician precisely what must be said. Apparently, in the City of Akron, being "informed" means a woman is to be told what the government decides she should be told, rather than what her physician believes is necessary to the making of a truly informed decision. Similar restrictive consent directions have been rejected by the courts, finding the language to be an intrusion into the

physician-patient relationship that is not justified by the state's interest in preserving the woman's health.

The importance of a sensitive and individualized approach to the obtaining of consent was aptly described by the U.S. Court of Appeals in Planned Parenthood League v. Belotti:

> [T]he uncontradicted expert testimony . . . indicated that requiring women seeking abortions to read this information ["description of the stage of development of the unborn child"] would cause many of them emotional distress, anxiety, guilt, and in some cases increased physical pain -- and it is of course by its impact on women in that stressful situation, rather than on judges or other detached readers, that the information must be measured.

641 F.2d at 1021.

The likelihood of negative effects on the woman's health from such consent requirements was recognized by both of the lower courts in the Planned Parenthood Association v. Ashcroft litigation. 655 F.2d at 868. As discussed fully at Point I, supra, numerous other courts have examined statutes prescribing the content of the information to be given to a woman seeking an abortion. In none of those cases did the court find a positive relationship between the required information and the woman's health; indeed, courts have tended to find that such information can be damaging to health interests. See, e.g., Leigh v. Olson, 497 F. Supp. at 1345.

These elaborate prescriptions for controlled consent inject the state into the decision-making process by placing the doctor in the "undesired and uncomfortable straitjacket" warned against in Danforth, and are unconstitutional. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

(2) The attending physician counseling requirement.

The attending physician counseling restriction prescribes a course of conduct without regard for the physician's professional judgment or the woman's medical needs. It applies to every woman who seeks an abortion, whether or not she has been counseled by her pri-

vate physician prior to referral to a clinic for the specialized services it provides. This state-imposed obligation creates the kind of "straitjacket" found objectionable by this Court in Danforth, and is impermissble under Roe. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

The attending physician requirement is not only burdensome, but inimical even to meet the asserted need: protection of the woman's health. Charles v. Carey, 627 F.2d at 784. Thus, strict scrutiny reveals no compelling state interest to justify this restriction.

(3) The mandatory waiting period requirement.

Similarly, statutes which fix inflexible requirements that abortions be postponed do not advance the state's interest in preserving the woman's health, and are thus unconstitutional. As discussed at Point I, supra, a state-mandated delay in the performance of an abortion deprives a woman of the right to end her pregnancy after she has voluntarily and knowingly decided to do so. This delay often, as noted at Point I, supra, results in postponing the abortion for a substantially longer period of time, since many facilities provide abortion services only once or twice a week. Such a delay can increase the risk to the woman's health. The fact

that imposition of a waiting period exacerbates, rather than ameliorates, the potential health risks has led the lower courts to invalidate such requirements. See, e.g., Planned Parenthood Association v. Ashcroft, 655 F.2d at 866 (48-hour waiting period),[24] Planned Parenthood League v. Bellotti, 641 F.2d at 1014 (24-hour waiting period); Charles v. Carey, 627 F.2d at 785 (24-hour waiting period); Margaret S. v. Edwards, 488 F.Supp. at 212 (24-hour waiting period); Women's Services, P.C. v. Thone, 483 F.Supp. 1022, 1050 (D. Neb. 1979), aff'd, 636 F.2d 206 (8th Cir. 1980), vacated and remanded on other grounds, 452 U.S. 911 (1981) (48-

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[24] The state has not sought review of this holding.

hour waiting period). This requirement reflects government attempts to coerce a woman to carry her pregnancy to term, irrespective of her physical and psychological condition; it fails to meet the strict scrutiny test.

CONCLUSION

For the foregoing reasons, the legislative provisions requiring that post-first trimester abortions be performed in hospitals, that physicians be required to convey specified information prior to obtaining a patient's consent for an abortion, that only the attending physician may counsel a patient at the stage of obtaining her consent, and that a woman must endure a mandatory waiting period after she has given her consent,

should be declared unconstitutional.

Respectfully submitted,

Phyllis N. Segal
Judith I. Avner
(Counsel of Record)
Anne E. Simon

NOW Legal Defense and
Education Fund
132 West 43rd Street
New York, N.Y. 10036

Jemera Rone
919 Third Avenue
New York, N.Y. 10022

Attorneys for Amici
Curiae[25]

---

[25] Attorneys for amici gratefully acknowledge the assistance in the preparation of this brief provided by Elise Berkower, Rebecca Arce, Naomi Cahn, Constance Buttner, William Lashner, Suzanne Senay, Susan Wells, Timm Whitney.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners,

—v.—

CITY OF AKRON, *ET AL.*,

Cross-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF AMICI CURIAE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., SOCIETY FOR ADOLESCENT MEDICINE, THE AMERICAN JEWISH CONGRESS, THE CENTER FOR POPULATION OPTIONS, THE AMERICAN JEWISH COMMITTEE, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS, THE NATIONAL COUNCIL OF JEWISH WOMEN AND CERTAIN MEDICAL SCHOOL DEANS AND PROFESSORS IN SUPPORT OF RESPONDENTS AND CROSS-PETITIONERS

(Names of individual *amici* appear within)

EVE W. PAUL
DARA KLASSEL
PAULA SCHAAP
Planned Parenthood Federation of America, Inc.
810 7th Avenue
New York, New York 10019
(212) 541-7800
Attorneys for Amici Curiae

INDIVIDUAL AMICI*

Ralph C. Benson, M.D.
Professor and Chairman Emeritus
Department of Obstetrics & Gynecology
Department of Oregon Health Sciences Center
Portland, Oregon 97201

Robert W. Berliner, M.D.
Dean
Yale University School of Medicine
333 Cedar Street
New Haven, Connecticut 06520

Daniel K. Bloomfield, M.D.
Dean
School of Basic Medical Sciences
Urbana-Champaign
University of Illinois, College of Medicine
Urbana, Illinois 61801

F.J. Bonte, M.D.
Director of Nuclear Medicine
The University of Texas
Health Science Center
5323 Harry Hines
Dallas, Texas 75235

Nicholas J. Cotsonas, Jr., M.D.
Professor of Medicine
University of Illinois at Chicago
P.O. Box 6998
Chicago, Illinois 60680

---

*Titles and affiliations for identification purposes only.

Robert D. Coye, M.D.
Professor Pathology Department
Wayne State University School of Medicine
9374 Scott Hall
540 East Canfield
Detroit, Michigan 48201

Morton C. Creditor, M.D.
Professor of Clinical Medicine
University of Illinois
College of Medicine
840 South Wood, Room 1028
Hospital Addition
Chicago, Illinios 60612

Preston V. Dilts, Jr., M.D.
Professor and Chairman
Department of Obstetrics and Gynecology
University of Tennessee
853 Jefferson Avenue
Memphis, Tennessee 38163

Robert H. Ebert, M.D.
Former Dean, Caroline Shields Walker Professor Emerit
Harvard Medical School
President, Milbank Memorial Fund
1 East 75th Street
New York, New York 10021

Kenneth Edelin, M.D.
Professor and Chairman
Department of Ob/Gyn
Boston University School of Medicine
720 Harrison Ave, Suite 201
Boston, Massachusetts 02118

T.N. Evans, M.D.
Past President of the American Gynecological Society
Past President of the American College of Obstetricians & Gynecologists
Professor and Chairman of Gynecology and Obstetrics
Wayne State University School of Medicine
Detroit, Michigan 48201

Henry W. Foster, Jr., M.D.
Professor and Chairman
Department of Ob/Gyn
Meharry Medical College
1005 18 Avenue North
Nashville, Tennessee 37208

Fritz Fuchs, M.D.
Professor of Obstetrics and Gynecology
Cornell University Medical College
New York, New York 10021

John W. Greene, Jr., M.D.
Professor and Chairman
Department of Ob/Gyn
University of Kentucky Medical Center
Lexington, Kentucky 40506

T. Terry Hayashi, M.D.
Professor and Chairman
Department of Obstetrics & Gynecology
Magee Womens Hospital
Forbes & Halket
Pittsburgh, Pennsylvania 15213

Charles H. Hendricks, M.D.
Professor and Emeritus Chairman Ob/Gyn
University of North Carolina
Chapel Hill, North Carolina 27514

Lawrence L. Hester, Jr., M.D.
Professor and Chairman
Department of Ob/Gyn
Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29403

Irwin H. Kaiser, M.D.
Professor
Department of Obstetrics & Gynecology
The Hospital of Albert Einstein
College of Medicine
1825 Eastchester Road
Bronx, New York 14061

Raymond H. Kaufman, M.D.
Professor and Chairman
Department of Ob/Gyn
Baylor College of Medicine
Houston, Texas 77030

Thomas H. Kirschbaum, M.D.
Professor and Chairman
Department of Obstetrics and Gynecology
Michigan State University
East Lansing, Michigan 48824

Schuyler G. Kohl, M.D.
Professor
Department of Obstetrics & Gynecology
Downstate Medical Center
450 Clarkson Avenue
Brooklyn, New York 11203

Kermit E. Krantz, M.D., Litt.D.
Professor and Chairman
Department of Gynecology and Obstetrics
University of Kansas Medical Center
Kansas City, Kansas 66103

James H. Lee, Jr., M.D.
Professor and Chairman
Department of Obstetrics & Gynecology
Jefferson Medical College
Thomas Jefferson University
1025 Walnut Street
Philadelphia, Pennsylvania 19107

Harry M. Little, Jr., M.D.
Professor
Department of Ob/Gyn
University of Texas Medical Branch
Galveston, Texas 77550

Sherman M. Mellinkoff, M.D.
Dean
UCLA School of Medicine
Los Angeles, California 90024

Frederick Naftolin, M.D., D.Phil.
Professor and Chairman
Department of Obstetrics and Gynecology
Yale University School of Medicine
Chief, Department of Obstetrics &
Gynecology
Yale-New Haven Hospital
333 Cedar Street
New Haven, Connecticut 06510

Kenneth R. Niswander, M.D.
Professor and Chairman
Department of Ob/Gyn
University of California at Davis
Sacramento, California 95817

Roy T. Parker, M. D.
Professor & Chairman Emeritus
Department of Obstetrics & Gynecology
Duke University Medical Center
Durham, North Carolina 27710

Ben M. Peckham, M.D.
Professor and Chairman
Department of Ob/Gyn
University of Wisconsin
Medical School
1300 University Avenue
Madison, Wisconsin 53706

L. Charles Powell, Jr., M.D.
Professor
Department of Ob/Gyn
University of Texas Medical Branch
Galveston, Texas 77550

Seymour L. Romney, M.D.
Professor of Gynecology and Obstetrics
Albert Einstein College of Medicine
1300 Morris Park Avenue
Bronx, New York 10461

Richard H. Schwarz, M.D.
Professor and Chairman
Department of Obstetrics and Gynecology
State University of New York
Downstate Medical Center
450 Clarkson Avenue
Brooklyn, New York 11203

Joseph Seitchik, M.D.
Professor and Past Chairman
Department of Ob/Gyn
University of Texas
Health Science Center at
San Antonio Medical School
7703 Floyd Curl Drive
San Antonio, Texas 78284

Robert J. Slater, M.D.
Director of Medical Programs
National Multiple Sclerosis Society
205 E 42 Street
New York, New York 10017

William N. Spellacy, M.D.
Professor and Head
Department and Obstetrics-Gynecology
University of Illinois College of Medicine
840 South Wood Street
Chicago, Illinois 60612

Donald P. Swartz, M.D.
Professor and Former Chairman
Department of Obstetrics & Gynecology
Albany Medical College
Albany, New York 12208

Allan P. Weingold, M.D.
Professor and Chairman
Department of Ob/Gyn
George Washington University
2150 Pennsylvania Avenue NW
Washington, D.C. 20036

J. Robert Willson, M.D.
Professor
Department of Gynecology & Obstetrics
University of Michigan
Medical Center
Ann Arbor, Michigan 48104

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES.....xi

INTEREST OF AMICI.....1

SUMMARY OF ARGUMENT.....5

ARGUMENT

1. SECTION 1870.06 (B) OF THE AKRON ORDINANCE UNDULY BURDENS A WOMAN'S RIGHT OF CHOICE REGARDING ABORTION AND ABRIDGES FIRST AMENDMENT RIGHTS OF PHYSICIANS AND PATIENTS...7

   A. Section 1870.06 (B) Unduly Burdens A Woman's Right of Choice Regarding Abortion.....7

   B. Section 1870.06 (B) Abridges First Amendment Rights of Physicians and Patients.....28

      1. Section 1870.06 (B) violates physicians' first amendment right to be free from state compelled speech.....28

      2. Section 1870.06 (B) abridges patients' first amendment right to refuse to listen to the state's ideological messages.....33

Page

II. SECTION 1870.06 (C) OF THE AKRON ORDINANCE, REQUIRING INFORMED CONSENT COUNSELING BY THE ATTENDING PHYSICIAN, SIGNIFICANTLY INTERFERES WITH A WOMAN'S RIGHT TO ABORTION AND IS NOT JUSTIFIED BY ANY STATE INTEREST.....37

III. SECTION 1870.07 OF THE AKRON ORDINANCE, THE TWENTY-FOUR HOUR WAITING PERIOD, WOULD HAVE A SIGNIFICANTLY HARMFUL IMPACT ON A WOMAN'S RIGHT TO ABORTION AND DOES NOT SERVE ANY STATE INTEREST.....47

IV. SECTION 1870.03 OF THE AKRON ORDINANCE, REQUIRING THAT ALL POST-FIRST TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONAL BECAUSE IT IS NOT A REASONABLE MEANS OF PROTECTING MATERNAL HEALTH.....59

V. SECTION 1870.05 (B) OF THE AKRON ORDINANCE, REQUIRING PARENTAL OR JUDICIAL CONSENT TO MINORS' ABORTIONS, PERMITS AN UNCONSTITUTIONAL VETO OF A MINOR'S ABORTION CHOICE.....62

CONCLUSION.....65

APPENDIX A

TABLE OF AUTHORITIES

Page (s)

CASES:

Abington School District v. Schempp, 374 U.S. 203 (1963).....36

Akron Center for Reproductive Health v. City of Akron, 479 F.Supp. 1172 (N.D. Ohio 1979), aff'd in part, rev'd in part, 651 F.2d 1198 (6th Cir. 1981)..... passim

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Carey v. Population Services International, 431 U.S. 678 (1977).....39

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980).....10, 18, 38 39, 46, 48

Colautti v. Franklin, 439 U.S. 377 (1979).....9, 27

Connecticut v. Menillo, 423 U.S. 9 (1975).....12

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Elrod v. Burns, 427 U.S. 347 (1976).....30

Page (s)

Gary-Northwest Indiana Women's Services v. Bowen, 496 F.Supp. 894 (N.D. Ohio 1980), affirmed, ____ U.S. ____, 101 S.Ct. 2012, 68 L.Ed.2d 321 (1981).....59

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Lehman v. Shaker Heights, 418 U.S. 298 (1974).....35

Leigh v. Olson, 497 F.Supp. 1340 (D.N.D. 1980).....48

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Page (s)

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Roe v. Wade, 410 U.S. 113 (1973).....12, 26, 30 56

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Page (s)

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Wooley v. Maynard, 430 U.S. 705 (1977).....29, 30, 34

CONSTITUTION, STATUTES AND ORDINANCE

U. S. Constitution:

First Amendment.....28 -36

Fourteenth Amendment.....passim

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N.H. Rev. Stats.Ann. § 507-C:2 (Supp.1979).....15, 16

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MISCELLANEOUS

Memorandum from Dr. Stanley Henshaw, Alan Guttmacher Institute (August 20, 1982).....60, 61

INTEREST OF AMICI*

Planned Parenthood Federation of America, Inc. (PPFA) is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. It is the leading national voluntary public health organization in the field of family planning. PPFA has 190 affiliates in forty-three states and the District of Columbia. These affiliates operate approximately 691 family planning clinics offering services to the public. Thirty-nine affiliates offer abortion services as part of their program. Most Planned Parenthood affiliates which do not perform abortions offer pregnancy counseling and referral.

The National Family Planning and Reproductive Health Association, Inc. (NFPRHA) is a national private non-profit membership organization, headquartered in Washington, D.C., devoted to the improvement and expansion of the delivery of family planning and reproductive health care services throughout the United States. With over 1300

*All parties have given their consent to the filing of this brief in letters filed with the Clerk of this Court.

members, it is the largest organization in the nation composed of providers and consumers of family planning and reproductive health care services.

The Association of Planned Parenthood Physicians, Inc. (APPP) is a New York not-for-profit corporation APPP has 670 members, all of whom are physicians or health professionals associated with family planning.

The Society for Adolescent Medicine is a national organization of health care providers to the adolescent age population. It consists of 900 active members all of whom are physicians and other health professionals.

The American Jewish Congress, a national organization of American Jews, was founded to protect the fundamental freedom of Jews and all Americans. It neither favors nor opposes abortion but believes that a woman's decision whether to undergo abortion must be her own, uncoerced by government.

The Center for Population Options (CPO) is a national organization concerned with the prevention of unintended adolescent pregnancy. CPO's projects are designed to assist adolescents in making informed choices about sex and parenthood. CPO believes that the adolescent's option as to whether or not to have an abortion must be maintained.

The American Jewish Committee (AJC) is a national organization which was founded in 1906 for the purpose of protecting the civil and religious rights of Jews. It believes that this goal can best be accomplished by helping to preserve the constitutional rights of all Americans. Specifically, the AJC supports access to abortion on a voluntary basis as an important component of comprehensive and effective health care and as part of our traditional concern for individual liberty, privacy and free choice.

The American Psychiatric Association is the nation's largest organization of physicians who specialize in the practice and study of psychiatry; approximately 27,000 of the nation's 34,000 psychiatrists are members. The Association has long had a policy

favoring medically appropriate abortions, because the opportunity to obtain such abortions implicates major psychiatric concerns.

The American Association of Sex Educators, Counselors and Therapists is a national non-profit membership organization. Its aims are to assist those professionals responsible for sex education, counseling and therapy programs by providing standards of competency in these areas.

The National Council of Jewish Women has 100,000 members. It has resolved to work to protect a woman's right to reproductive freedom.

Individual Professors, Physicians and Medical School Deans practice obstetrics and gynecology as their medical specialty or are responsible for the education of medical students and residents, some of whom are in training in the specialty of obstetrics and gynecology.

Amici submit this brief in order to demonstrate for the Court the impact of the Akron, Ohio Ordinance on the health and welfare of pregnant women.

SUMMARY OF ARGUMENT

Amici submit this brief in support of Cross-Petitioners/Respondents, Akron Center for Reproductive Health, et al.

Section 1870.06(B) of the Akron Ordinance, requiring that a physician recite to every patient a forty-four line script, including descriptions of fetal anatomy and false or unproven statements regarding abortion risks and consequences, violates a woman's right to rely upon the unimpeded advice of her physician in deciding whether or not to have an abortion. In so far as this section of the Ordinance compels speech affirming certain beliefs and opinions, physicians' first amendment rights are violated. In so far as patients are required to listen to these statements as a precondition to exercising their right to abortion, their first amendment right to refuse the state's ideological messages is violated.

Section 1870.06(C) of the Ordinance, requiring that the attending physician personally conduct informed consent counseling, impedes the physicians' exercise of best medical judgment by prohibiting the delegation of

the informing function to a trained paraprofessional.

Section 1870.07 of the Ordinance, requiring that a woman wait twenty-four hours between the time she consents to and receives an abortion, will result in lengthy delays, well beyond twenty-four hours, and increase health risks and financial costs. No state interest justifies such an inflexible requirement.

Section 1870.03 of the Ordinance, requiring performance of all post-first trimester abortions in hospitals, is not a reasonable means of protecting maternal health. The Court is here referred to amici's argument on this point in a brief filed in a related case. A new study demonstrates the difficulty in obtaining dilatation and evacuation abortions in hospitals.

Section 1870.05(B) of the Ordinance, requiring parental or judicial consent to minors abortions, impermissibly grants a veto power to third parties of even a mature minor's abortion choice.

I. SECTION 1870.06 (B) OF THE AKRON ORDINANCE UNDULY BURDENS A WOMAN'S RIGHT OF CHOICE REGARDING ABORTION AND ABRIDGES FIRST AMENDMENT RIGHTS OF PHYSICIANS AND PATIENTS

A. Section 1870.06 (B) Unduly Burdens A Woman's Right of Choice Regarding Abortion

Section 1870.06 (B) of the Akron Ordinance requires the physician to orally recite certain statements to every woman requesting an abortion, including inter alia:

> (3) That the unborn child is a human life from the moment of conception and (describe) in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

and

> (5) That abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may

have, and can result in severe emotional disturbances.

The Ordinance compels the physician, on pain of criminal penalty, to make these statements regardless of his or her judgment as to their veracity or their effect on the patient's well-being. Moreover, every woman, regardless of her emotional state or desire to receive the prescribed information, must listen to these statements as a pre-condition of obtaining a legal abortion. Because this section of the Ordinance places unjustified obstacles in the path of both the woman and the physician upon whom she is entitled to rely for advice in connection with her abortion decision, it must be held unconstitutional.

In affirming a woman's right to abortion, this Court has repeatedly linked that right to the physician's unimpeded ability to exercise responsible professional judgment in determining the need for and method of effectuation of the abortion. This is because the woman's exercise of her abortion right is encumbered "by placing

obstacles in the path of the doctor upon whom she (is) entitled to rely for advice in connection with her decision." Whalen v. Roe, 429 U.S. 589, 604 n. 33 (1977). Accordingly, the Court has repeatedly struck down laws which intrude on the physician's discretion in the abortion context. See e.g., Doe v. Bolton, 410 U.S. 179, 199 (1973) (striking down requirement of second doctor and committee concurrence in attending physician's judgment that an abortion is necessary); Colautti v. Franklin, 439 U.S. 377, 396-97 (1979) (striking down law which did not leave physician sufficient discretion to make his best medical judgment regarding fetal viability).

The Court has extended this principle to states' efforts to assure that women give informed and voluntary consent to abortion. In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), Missouri's requirement that a woman certify in writing that her consent to abortion was informed and freely given was upheld. The Court cautioned, however, that should

the term "informed consent" be interpreted to mean more than "the giving of information to the patient as to just what would be done and... as to its consequences," the statute "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." Id. at 67 n. 8.

Relying on Danforth's proviso, four federal courts of appeals, including the court below, and numerous federal district courts, have struck down laws similar to Akron's as constituting just such an unconstitutional "straitjacket" for the woman's physician. See e.g., Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006 (1st Cir. 1981), Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198 (6th Cir. 1981), Charles v. Carey, 627 F.2d 772 (7th Cir. 1980), Planned Parenthood Association of Kansas City, Mo. v. Ashcroft, 655 F. 2d 848 (8th Cir. 1981), Margaret S. v. Edwards, 488 F.Supp. 181 (E.D.La. 1980), Planned Parenthood

of Rhode Island v. Roberts, 530 F.Supp. 1136 (D.R.I. 1982).

The Akron Ordinance goes far beyond a simple requirement of disclosing what is to be done and its consequences. Rather, it requires the physician to recite a forty-four line script regardless of his best medical judgment and his patient's wishes. This requirement is more than a mere annoyance. It requires the physician to speak and the patient to listen to a text containing information which may be emotionally distressing, if not physically harmful, and is in part empirically false and medically irrelevant. It is precisely the sort of "uncomfortable straitjacket" the Court envisioned in Danforth.

In establishing the parameters of what is permissible and impermissible in abortion consent laws, this Court should look to the standards already established by the law of medical malpractice for obtaining informed consent to all types of medical care. Physicians daily rely on these standards to determine what disclosures to make

to their patients. The Court in Danforth implied that this was the appropriate measure of the physician's duty. Its statement that informed consent means "what is to be done and its consequences" is an obvious reference to the tort law standard. Further, it is clear that the Court upheld the Missouri requirement because it required no greater disclosure than would be warranted for any other medical procedure. 428 U.S. at 67. This approach is in accord with this Court's long recognition that the judicial remedies generally afforded by the civil law for abuses of medical judgment afford adequate protection to the abortion patient. Roe v. Wade, 410 U.S. 113, 166 (1973). In fact, it is the very existence of these remedies that have precluded further state intervention in a woman's abortion decision during the first trimester. Id. See also, Connecticut v. Menillo, 423 U.S. 9, 11 (1975).

The physician's common law duty to inform a patient about the nature and risks of a proposed treatment

has arisen out of a recognition that "(e)very human being of adult years and sound mind has a right to determine what shall be done with his own body," and that "(t)rue consent to what happens to one's self is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972). Consequently, a physician who has not obtained informed consent from a patient may be liable for damages if an undisclosed risk eventuates in injury to the patient. Id. at 790.

The elements of informed consent at tort include disclosure of the nature of a proposed treatment, its risks and benefits and its

alternatives. Id. at 781-82[1/]. The adequacy of disclosure has traditionally been judged against community medical standards, but the modern view is to measure the physician's duty by the patient's needs.[2/] Every risk, no matter how small or remote, need not be revealed. The test for whether or not a particular peril should be revealed is its materiality to the patient's decision.

1/ See also, Ohio Rev. Code Ann. § 2317.54 (1981) Consent is valid and effective when the patient signs a written statement that sets forth "in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures." Thus, the City of Akron has singled out abortion for a higher standard of disclosure than is currently required by Ohio law generally. Such discrimination has been recently held to be grounds for striking down a similar "informed consent" law. Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136, 1152 (D.R.I. 1982).

2/ A. Rosoff, Informed Consent: A Guide for Health Care Providers 38 (1981) (hereinafter cited as "Informed Consent")

> (T)he issue of nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, ... (it) was unreasonably inadequate is an imposition of liability legally or morally justified.

464 F.2d at 787.

Despite its emphasis on patient autonomy and the right to make a free choice, the law of informed consent, as expressed in both statute and case law, recognizes certain exceptions. In emergencies, a physician need not make full disclosure.[3/] Nor need he do so when a patient expresses a desire not to hear certain information.[4/]

3/ See generally, Informed Consent, supra note 2 at 14-19 and cases cited therein. See also, Ohio Rev. Code Ann. § 2317.54 (1981), supra note 1; Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972) and sources cited therein.

4/ See. e.g., 18 Del. Code Ann. § 6852 (Cum. Supp. 1980) (In a defense to a civil suit for damages a physician may assert that "the injured party assured the health care provider he or she would undergo the treatment regardless of the risk involved or that he or she did not want to be given the information or any part thereof to which he or she could otherwise be entitled.") Similar provisions are included, inter alia, in N.H. Rev. Stats. Ann. § 507-C:2 (Supp. 1979); N.Y. Public Health Law, 44 McKinney § 2805-d (McKinney 1977); Utah Code Ann. § 78-145 (1977).

Finally, a "therapeutic privilege" is widely recognized[5/] whereby a physician may withhold certain information

> when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.

464 F.2d at 789.

5/ See e.g., 18 Del. Code Ann. § 6852 (Cum.Supp. 1980) (Allows physicians to assert as a defense to an action for damages for failure to obtain informed consent that "it was reasonable for the health care provider to limit the extent of his or her disclosures of the risks of the treatment, procedures or surgery to the injured party because further disclosure could be expected to affect, adversely and substantially, the injured party's condition, or the outcome of the treatment, procedure or surgery." Thomas v. Berrios, 348 So. 2d 905 (Fla. Ct. App. 1977); N.H. Rev. Stat. Ann. § 507-C:2 (Supp.1979). See generally, Informed Consent, supra note 2 at 54-56 and 75-185. (State-by-state analysis of statutory and case law on informed consent.)

The Akron Ordinance conflicts with the traditional legal doctrine of informed consent primarily in its inflexibility. It does not allow the physician to tailor the information to the needs of the individual patient. Nor does it give the physician the discretion to adjudge the materiality of a particular fact to a particular patient's situation, to withhold even relevant information that would be harmful to a patient or to accede to a patient's wish not to hear the information.

There are many situations in which a physician might conclude that listening to a detailed description of fetal anatomy is not relevant to every patient's abortion decision or should be withheld because it would cause a particular patient undue anxiety, even physical pain. Many patients may simply not want to hear this information prior to receiving an abortion. As the First Circuit stated in striking down a requirement that women read a description of the fetus prior to obtaining an abortion,

> (f)irst, the information is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement. Second, the uncontradicted expert testimony at the hearing below indicated that requiring women seeking abortions to read this information would cause many of them emotional distress, anxiety, guilt and in some cases increased physical pain... In addition, these effects might well be thought likely to be even greater for certain classes of women for whom the abortion decision is intrinsically more stressful, including those who had been rape victims, who were very young, or who sought an abortion because of danger to their own health or indications that the fetus...might be born deformed... Finally, ...the uncontradicted testimony indicated both that most women would not want to hear such a description just prior to having an abortion and that most physicians would not consider it good medical practice to provide one...

641 F.2d at 1021-22. See also, Charles v. Carey, 627 F.2d 772, 784 (7th Cir. 1980). ("The prospect of such 'required reading' for the woman who elects to abort a fetus because of serious genetic defects or because her own health is in danger is punitive to the woman and compromising to the physician's efforts to do what is best for her.")

Section 1870.06 (B)(5)'s list of risks which must be disclosed in all cases contains statements which the majority of physicians would adjudge immaterial to a woman's abortion decision because they are false, still scientifically unproven or extremely remote.

The section directs the physician to tell a woman that abortion is major surgery. This statement is simply not true, at least for the 91% of abortions performed in the first trimester of pregnancy.[6/] Early abortion is in fact one of the safest surgical procedures.

The mortality rate for legally induced abortion in the first trimester is 1.5 deaths per 100,000 procedures.[7/] By comparison, a routine tonsillectomy is twice as risky and an appendectomy 100 times more dangerous.[8/]

6/ U.S. Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: 1978 4 (1980).

7/ Cates & Grimes, Morbidity and Mortality of Abortion in the United States, Table 4 in Abortion and Sterilization: Medical and Social Aspects (Hodgson ed. 1981) (hereinafter "Morbidity and Mortality").

8/ Id. at 168-69. A "major operation" is defined as "An extensive, relatively difficult surgical procedure, frequently involving a major cavity of the body, or
(footnote continued on next page)

The risk of abortion at this stage is similar to that of a penicillin injection.[9] Accord, Margaret S. v. Edwards, 488 F.Supp. 181, 210 (E.D. La. 1980); Akron Center for Reproductive Health v. City of Akron, 479 F.Supp. 1172, 1207 (N.D. Ohio 1979), aff'd, 651 F.2d 1198 (6th Cir. 1981).

The Ordinance further requires the physician to tell the woman that abortion may result in "serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies." Even early suction curettage abortion does carry some risk of uterine perforation (0.1 to 0.2 perforations per 100 procedures)[10] infection (0.1 to 2.2 per 100 procedures)[11] and hemorrhage (0.05 to 4.9 pe

(footnote continued from previous page)
requiring general anesthesia; one which demands of the surgeon a special degree of experience or skill." Gould Medical Dictionary (4th ed. 1979). First trimester suction curettage abortion can hardly be said to fit this definition.

9/ Cates et al., Abortion as a treatment for unwanted pregnancy: the number two sexually-transmitted condition, 12 Advances in Planned Parenthood 115, 120 (1978).

10/ Morbidity and Mortality, supra note 7 at 163.

11/ Id. at 162.

100 procedures).[12] These complications are rarely "serious," however. For example, only about one in seven cases of hemorrhage requires blood transfusion to replace lost blood.[13] Infection usually responds to treatment with antibiotics, but hospitalization is sometimes necessary. Moreover, sterility is seldom a direct result of abortion but usually results from rare but extemely serious complications that may occur. For example, infection can, in very rare cases, become so extensive that hysterectomy is necessary. Without the foregoing caveat, however, it is misleading to say that "abortion...can result...in sterility."

The most recent studies indicate that there is no evidence linking one previous induced

12/ Id. Reported rates of hemorrhage vary so widely because of "lack of uniformity in definition of hemorrhage and imprecision in identifying blood loss." Id.

13/ Id.

abortion to later spontaneous abortion (miscarriage).[14/] The studies are in conflict on the relationship between repeat abortions and the outcome of a future pregnancy. Some studies have found a correlation; others have not.[15/] One recent Hawaii study examined the records of 16,691 women who obtained legal abortions in the state between 1970 and 1974. It found that the frequency of miscarriage was more related to the length of time a woman waited before becoming pregnant again after having had an abortion than to the number of abortions she had had. Women whose previous pregnancies had resulted in either abortion or live birth were more likely to miscarry if they conceived again within a year than if they waited

14/ No Increased Risk of Spontaneous Abortion Among Women With a Previous Induced Abortion, 13 Family Planning Perspectives 238 (1981).

15/ Id.

longer to become pregnant again.[16]

The evidence on whether induced abortion can cause future premature births is likewise inconclusive. A multinational study conducted by the World Health Organization found no correlation between delivering a premature or low-birth weight infant and a previous induced abortion by the vacuum aspiration method, the most widely used method in the United States.[17] If dilatation and sharp curettage was used, however, there was some indication of a slightly increased risk of prematurity, although another research project found no correlation, even with this method.[18] There is somewhat clearer indication that when abortion is complicated by infection or there are multiple abortions, the risk of prematurity may be increased, but the results are still inconclusive.[19]

16/ Id. at 239.

17/ D. Main, Does Abortion Affect Later Pregnancies? 11 Family Planning Perspectives 98, 99 (1979).

18/ Id. at 100.

19/ Id.

The Akron Ordinance's requirement that a woman be told that abortion "may leave essentially unaffected or may worsen any existing psychological problem and can result in severe emotional disturbances" likewise distorts the severity of abortion sequelae. Studies conducted on women receiving legal abortion show that post-abortion psychosis is extremely uncommon and has a considerably lower incidence than such disturbances following childbirth (puerperal psychosis).20/ One study of abortion patients showed that, although nearly all women approach abortion with some degree of ambivalence and emotional distress, nearly half of women report resolving their problems within four months of the procedure. The predominant feeling among the group surveyed was relief that the pregnancy had been terminated. Only 24% of those who had wanted the pregnancy and 11%

20/ Brewer, C. Incidence of Post-Abortion Psychosis: a Prospective Study, 1 British Medical Journal 476 (1977).

of those who had not wanted it experienced depression four months later. Continued disturbance about the abortion resulted most prominently from lack of support in the decision from the male partner.[21/]

Another way in which the Akron Ordinance forces the physician to act against his patient's best interests is by not allowing an exception to the disclosure requirement in emergency situations. This is an exception universally recognized in tort law.[22/] Its omission can hardly be viewed as inadvertent, since section 1870.12 specifically allows the physician to dispense with the "Informed Consent" section's requirement for a parent's co-signature on a consent form in emergencies, yet fails to allow the physician to dispense with the required recitations. Thus, even when a woman's life is in danger a physician must recite the

21/ Freeman, E. Abortion: Subjective Attitudes and Feelings, 10 Family Planning Perspectives 150, 153, 154. (1978).

22/ Note 3, supra.

required script. A physician faced with an unconscious patient obviously acts at his or her peril vis a vis the criminal law in performing even a life-preserving abortion.

The foregoing demonstrates that the Akron Ordinance conflicts with the accepted medical/ legal meaning of informed consent by requiring the physician to make statements which he or she may rationally conclude to be medically irrelevant, false and/or harmful to a patient. The statute presents a conflict with a physician's professional duty and judgment on an even more elementary level. It is axiomatic that the law cannot require a physician to give information which is simply outside the realm of medical competence. This is typified by the Act's requirement that the doctor tell the woman that "her unborn child is a human life from the moment of conception." The beginning of human life is a personal, philosophic or religious value judgment, not a medical or scientific fact. Roe v. Wade, 410 U.S. 113, 159-61 (1973).

Requiring a physician to make statements which are outside the realm of his medical competence and which may be directly contrary to his or the woman's deeply held personal beliefs is perhaps the most offensive "straitjacket" of all.23/

In summary, the Akron Ordinance poses a direct and significant interference with a woman's abortion choice by burdening her physician with criminal penalties for failure to make statements in conflict with his or her professional judgment.24/

23/ See discussion at section I.B. infra on first amendment implications.

24/ The burdens on the physician are heightened by the statute's vagueness. For example, the physician must, upon request, provide the woman with a "list of agencies" to help her carry her pregnancy to term, yet there is no indication of what such a list must comprise in order to be legally adequate. The required disclosure of fetal anatomy is "including but not limited to" a list of fetal attributes. Yet a physician cannot know when he has completed a legally adequate description. The importance of statutory vagueness in chilling the physician's willingness to perform abortions and, hence, a woman's ability to receive them was recognized in Colautti v. Franklin, 439 U.S. 377, 390-97 (1979).

The search for any legitimate state interest to justify this intrusion is pointless. "There is no rational reason, much less a compelling state interest, that justifies forcing physicians to give women information that physicians consider injurious to the woman's health or simply untrue." Planned Parenthood of Kansas City v. Ashcroft, 655 F.2d 848, 868 (8th Cir. 1981). The Constitution cannot tolerate such draconian means of pursuing the otherwise admirable aim of assuring a woman's free and informed choice.

B. Section 1870.06 (B) Abridges First Amendment Rights of Physicians and Patients.

I. Section 1870.06 (B) violates physicians' first amendment right to be free from state compelled speech.

As demonstrated in the foregoing discussion, section 1870.06 (B) requires physicians to affirm beliefs they may not hold, to convey to patients medical opinions with which they may disagree, and to utter statements as proven facts which they may believe to be empirically false or hypothetical. By so doing, the Ordinance also violates a central guarantee of the first

amendment: that an individual has a right to be free from government coerced speech in matters of belief, opinion and ideology.

> A system which secures the right to proselytize religious, political, and ideological causes must also guarantee the concomitant right to decline to foster such concepts. The right to speak and the right to refrain from speaking are complementary components of the broader concept of "individual freedom of mind"...where the state's interest is to disseminate a ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier of such a message.

Wooley v. Maynard, 430 U.S. 705, 714, 717 (1977).

Accordingly, this Court has invalidated state action compelling individuals to utter by word or sign beliefs that they did not hold. For example, in West Virginia State Board of Education v. Barnette, 319 U.S. 624 (1943), this Court held that the flag salute and pledge of allegiance could not be compelled, for to do so would be to "prescribe what shall be orthodox in politics, religion or other matters of opinion." Id. at 642. And in

Wooley v. Maynard, the Court struck down New Hampshire's law against covering the motto "live free or die" on license plates on the ground that it forced individuals to foster an idea they found morally objectionable. 430 U.S. at 715. See also, Elrod v. Burns, 427 U.S. 347 (1976)

The Akron Ordinance falls squarely within the type of state coerced speech this court has held unconstitutional. The best example of this is the requirement that the physicians tell the woman that her "unborn child is a human life from the moment of conception." This Court has explicitly held that the concept of "when life begins" is a matter of religious and philosophical belief. Roe v. Wade, 410 U.S. 113, 160 (1973). The Ordinance thus forces physicians to be couriers of an ideological message in identical manner to the plaintiffs in Maynard who had to bear the motto

"live free or die" on their license plates.[25]

In like manner, the Ordinance requires physicians to tell their patients an abortion is major surgery, a matter of opinion with which most physicians disagree, and to state as true abortion risks which many physicians will believe to be hypothetical, if not inaccurate.[26]

25/ In so far as views on the beginning of human life are part of religious value systems, requiring physicians to make a statement affirming that human life begins at conception may interfere with the free exercise component of the first amendment, as well as free speech. In McRae v. Califano, 491 F.Supp. 630 (E.D. N.Y. 1980), reversed sub nom Harris v. McRae, 448 U.S. 297 (1980) the Court found that in the Jewish legal view, "no person is in existence until the infant emerges from the womb into the world," Id. at 697, and the "mainstream Protestant view" is that "human personhood -- in the sense in which the person receives its maximum value in relation to the Christian faith ... does not exist in the earlier phases of pregnancy," Id. at 742. See Torcaso v. Watkins, 367 U.S. 488 (1961) (free exercise clause violated by requiring affirmation of belief in God as a condition of holding public office). Although this Court has held that beliefs in the propriety or impropriety of abortion are not so uniquely religious that anti-abortion legislation amounts to an establishment of religion, it has yet to deal with the question raised here, that requiring affirmation of the value and beginning of human life violates free exercise rights. See Harris v. McRae,448 U.S. 297, 319-320 (1980).

26/ See text surrounding notes 6 through 21 supra.

If the first amendment limits a state's authority to compel affirmation of ideologies and beliefs with which the individual disagrees, it must certainly protect an individual from being compelled to utter statements which are simply untrue.

The requirement that the physician describe the fetus to the woman also attempts to use the physician as the mouthpiece for the state's anti-abortion viewpoint. Although the information to be given is factual in nature, the real purpose of the requirement is not to inform but to dissuade women from having abortions. This is especially true in light of the fact that many patients will not consider this information relevant to their decision or even wish to hear it, and with regard to these patients, the physicia is forced into a role inconsistent with a good doctor-patient relationship. The First Circuit applied a similar first amendment analysis in striking down a Massachusetts fetal description requirement. The court first recognized that "the primary purpose of the required information is not so much factual as it is moral," and th

explained:

> To the extent that information may be imposed by the state it must be neutral and objective; coercive state indoctrination of particular values or ethical judgments is objectionable to First as well as Fourteenth Amendment principles. The state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights.

Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006, 1022 (1st Cir. 1981).

For the foregoing reasons, section 1870.06 (B) should be held to violate physicians' first amendment right to be free from state compelled speech.

2. Section 1870.06 (B) abridges patients' first amendment right to refuse to listen to the state's ideological messages.

Section 1870.06 (B) contains information which may be viewed as ideological in nature and may be offensive to individuals' deeply held religious and philosophical beliefs. By requiring all women to listen to this information as an absolute precondition of obtaining a legal abortion, the Ordinance violates the first amendment rights of captive auditors not to be accosted by the state's ideological messages.

Just as the right to speak freely necessarily encompasses a right to refrain from speaking at all, Wooley v Maynard, 430 U.S. 705, 714 (1977), so too the now established first amendment right to receive information and ideas, Stanley v. Georgia, 394 U.S. 557, 564 (1969), necessarily implies a right to refuse them:

> ...the Constitution protects more than just a man's freedom to say or write or publish what he wants. It secures as well the liberty of each man to decide for himself what he will read and to what he will listen. The Constitution guarantees, in short, a society of free choice.

Ginsberg v. N.Y., 390 U.S. 629, 649 (1968) (Stewart, J., concurring). On a number of occasions, this Court or the individual Justices have alluded to this right as circumscribing the state's power to impose political or otherwise offensive messages on captive audiences, most notably passengers on state-owned transit vehicles. See e.g., Public Utilities Commission v. Pollak, 343 U.S. 451 (1952)

(because radio programs broadcast on public buses did not contain "objectionable propaganda" they did not violate passengers' right to refuse to listen.) See also, Id. at 466 (Black, J., concurring); Id. at 467 (Douglas, J., dissenting); Lehman v. Shaker Heights, 418 U.S. 298, 307 (1974) (Douglas, J., concurring).

A woman sitting in a doctor's office or an abortion clinic, forced to listen to a state mandated anti-abortion lecture, is perhaps more "captive" than any of the auditors previously considered by the Court. Like the streetcar passenger, she "has no choice but to sit and listen, or perhaps sit and try not to listen." Public Utilities Commission v. Pollak, 343 U.S. at 469 (Douglas, J., dissenting). Yet, unlike the streetcar passenger who can avoid an offensive message by simply getting off the car, she has no realistic alternative available.

Legal abortion is the only safe means of terminating a pregnancy. To force a woman to choose between a legal abortion and avoiding an offensive state lecture is to violate both first and fourteenth amendment rights.27/

27/ In so far as a woman is forced to listen to information that is in conflict with her religious beliefs, the Ordinance violates the woman's right to free exercise of religion as well. See note 25 supra. See also, Abington School District v. Schempp, 374 U.S. 203, 288-89 (1963) (Brennan, J., concurring) (free exercise right to be excused from Bible reading in public schools).

II. SECTION 1870.06(C) OF THE AKRON ORDINANCE, REQUIRING INFORMED CONSENT COUNSELING BY THE ATTENDING PHYSICIAN, SIGNIFICANTLY INTERFERES WITH A WOMAN'S RIGHT TO ABORTION AND IS NOT JUSTIFIED BY ANY STATE INTEREST

Section 1870.06 (C) of the Akron Ordinance requires that the same physician who performs the abortion must personally provide his or her patient with the statutorily required "informed consent" information. This requirement prohibits the attending physician from delegating to another physician or to trained counselors the task of providing this information even when the doctor's best medical judgment dictates such delegation. Amici believe that the determination as to which health professional is best equipped to provide the informed consent information is best left to the professional judgment of the woman's attending physician. By dictating who should provide this information, the Akron Ordinance places unjustifiable "obstacles in the path of the doctor upon whom (the woman)

is entitled to rely for advice in connection with her decision". Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977). It is precisely the sort of "strait-jacketing" of medical practice this Court warned of in connection with laws dictating the content of the informed consent dialogue. Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 67 n.8.[28/] The court of appeals was correct in recognizing this and in holding the requirement unconstitutional. 651 F.2d at 1207. Accord, Charles v. Carey, 627 F.2d 772, 784 (7th Cir. 1980), Planned Parenthood of R.I. v. Roberts, 530 F.Supp. 1136, 1147 (D.R.I. 1982).

The attending physician counseling requirement directly burdens the woman's access to abortion in a number of ways. First, it makes abortions more expensive and less available. Second, it impedes good medical practice.

By requiring physicians, the most highly paid

28/ See page 10 supra and cases cited therein.

members of the health care delivery team,[29] to spend time imparting to patients information that can be communicated equally well, if not better, by a trained counselor, the Ordinance will inevitably raise the cost of abortions. Moreover, because of the shortage of trained physicians, the increased time demanded may result in decreased availability of abortions.[30] The federal district court in Rhode Island summarized this effect well:

> A primary component of the cost of an abortion is the cost of the doctor's time. One way to cut some of the costs of surgery is to restrict the use of doctor-time to those services that only the doctor can provide. In this way, a hospital or other medical facility can make the highest and best use of doctor's time and, concomitantly, reduce the cost of the peripheral services that make up the total package. For example,

29/ Amicus Planned Parenthood Federation of America's (PPFA's) affiliates who provide abortion services report that physician salaries are six or seven times that of the counselors who currently provide the informed consent information. See note 32, infra.

30/ Increased cost and decreased availability resulting from direct state regulation in the area of reproductive privacy have long been held by this Court to give rise to strict judicial scrutiny. Carey v. Population Services Int'l, 431 U.S. 678, 689 (1977); Doe v. Bolton, 410 U.S. 179, 193-95 (1973).

> (plaintiff) clinics keep the costs of abortions down by attempting to utilize doctor-time only for the actual surgery. The counselling and informing functions are performed by other professionals whose time is not as expensive as a doctor's. By not "under-employing" doctors, these clinics provide an abortion at its optimal cost. The clinics' practice helps alleviate the shortage discussed above. By utilizing a doctor's time in the most efficient fashion, the clinics free their doctors to do more of the things that only they are capable of doing. The State's "same physician" requirement will disrupt this method of proceeding, thereby increasing the cost of abortions and aggravating the increasing doctor shortage.

Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. at 1148. The plaintiffs' witnesses testified in the district court that the requirement, especially when coupled with the required waiting period, was "likely to lead to the shutdown of the clinics or a substantial increase in their operating cost."[31/] Affiliates of amicus Planned Parenthood Federation of America (PPFA), when questioned about the effect of a physician counseling requirement on their operations, answered almost unanimously that substantial, if not prohibitive, increased

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31/ Joint Appendix filed in the Court of Appeals (J.A.) 116, 222-224, 458, 521 as cited in Respondents' Consolidated Brief in Opposition to Certiorari at 20.

costs would result.[32/]

In addition to the financial and access burdens, the physician counseling requirement interferes with good medical practice. As the federal district court in Rhode Island noted,

> (m)uch of the testimony at trial indicates that the national trend is toward the use of trained and supervised "paraprofessionals" to deliver the information and counselling that leads to informed consent for any surgical procedure. This trend has developed in response to a national desire to lower the cost of medical care and to offset a national shortage of doctors, and in recognition of the fact that doctors often are not the best people to perform this function. Several doctors who testified in this case indicated that they felt that a trained counsellor could be much more effective in obtaining truly informed consent than could the attending physician. This is particularly true in the area of abortions where counselling skills may be as important to the success of the procedures as is surgical technique. Counsellors may also be better at searching out ambivalence or anxiety than would a physician.

530 F.Supp. at 1148 (emphasis added).

This "national trend" toward use of trained

32/ PPFA's thirty-nine affiliates which provide abortion services were surveyed informally regarding the effect that a law similar to Akron's would have on clinic operations. Twenty-eight responses were received. The information presented in this section and section III regarding affiliate clinic practice is based on that survey. PPFA affiliate abortion providers performed 80,000 abortions in 1981.

paraprofessionals, id., is well exemplified at abortion clinics run by affiliates of amicus PPFA. A survey of these providers[33/] showed that virtually all use non-physician counselors to provide the informed consent information in the first instance, with physicians available to answer any questions the woman may have. The clinics report that this practice cuts costs but also serves the overall health interests of the patients.

Counselors typically are academically trained with undergraduate or graduate degrees in sociology, psychology, counseling or social work or are nurses or nurse practitioners. They are selected for and trained in listening and communication skills. Their most important qualification is the ability to "respect, understand and empathize with the woman as an individual. A counselor must have a sincere belief in the right of the woman to make her own decision after she has explored all the options."[34/]

33/ See note 32 supra.

34/ Planned Parenthood Federation of America, Manual of Medical Standards and Guidelines, Section VII-C p.22 (December 15, 1977) (hereinafter "PPFA Manual")

Counselors also must have knowledge regarding the medical aspects of the abortion procedure, its risks, its benefits and all alternatives including carrying the pregnancy to term and keeping the child or placing it for adoption.[35/]

PPFA's affiliates believe that counselors have superior skills in listening to the woman and surfacing her concerns regarding her pregnancy. They believe counselors can impart the medical information to the woman on a level she can understand and that women will feel more comfortable asking questions seeking medical information of counselors than of physicians, who may be regarded as authority figures by their patients. PPFA's Memphis affiliate has experienced complying with a similar Tennessee law during 1979, 1980 and 1981. In order to secure a truly informed consent from patients the affiliate found it necessary to continue utilizing its non-physician counselors to supplement the physician counseling. The affiliate wrote in reply to PPFA's survey,

35/ Id.

> For many women in our patient population, the "physician mystique" still exists and they are more comfortable and relate more easily to the counselor...(the patients) were extremely reluctant to ask questions of the physician. A counselor's specific training and skills which have developed in active listening, non-verbal communication, and being non-judgmental, enable her to become more capable of imparting to the woman on her level the informed consent information.[36]

Delegation of counseling duties to trained paraprofessionals is not an abrogation of responsibility on the part of the physician. Physicians at PPFA affiliate abortion providers typically prepare or approve the medical fact sheets that form the basis for the informed consent counseling sessions and are required, by PPFA standards, to be available to answer the woman's questions.[37] The best insuror, however, of physician responsibility and the patient's receipt of informed consent is the present common law of medical malpractice,

36/ Reply of Memphis Association for Planned Parenthood to survey, note 32 supra. Survey answers are on file at PPFA offices, New York New York.

37/ PPFA Manual, supra note 34 at

which holds a physician liable in damages for failure to secure informed consent.[38] That law does not require that the patient receive the information from any particular source, but does hold the physician responsible if the information is not imparted.[39]

For all the foregoing reasons, good medical practice holds that a trained counselor can do a superior job in securing informed consent from an abortion patient, in addition to cutting costs substantially. Prohibiting physicians from delegating the duty of informing the patient to a counselor [40] thus significantly interferes with a woman's right to abortion. While Akron has advanced an interest in protecting the woman's health

38/ See discussion at pages 12-15 supra.

39/ A. Rosoff, Informed Consent: A Guide for Health Care Providers 45 (1981). See e.g., Stills v. Gratton, 55 Cal.App.3d 6298 (1976). In this regard, Respondents' contention that the Ordinance's requirement that the physician personally inform the patient merely reiterates "his common law and ethical duty" is incorrect. Brief for Petitioner City of Akron at 40.

40/ Significant burdens are also imposed by prohibiting the physician from delegating either the counseling or

(footnote continued on next page)

as a justification for the requirement, there is no indication of how this interest is served by a statute that forces physicians to act in a manner which is against good medical practice. For these reasons, the court of appeals' judgment that section 1870.06 (C) is unconstitutional should be affirmed.

(footnote continued from previous page)

the performance of the abortion to a physician colleague. See Charles v. Carey, 627 F.2d 772, 784, (7th Cir. 1980), Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136, 147 (D. R.I. 1982).

III. SECTION 1870.07 OF THE AKRON ORDINANCE, THE TWENTY-FOUR HOUR WAITING PERIOD, WOULD HAVE A SIGNIFICANTLY HARMFUL IMPACT ON A WOMAN'S RIGHT TO ABORTION AND DOES NOT SERVE ANY STATE INTEREST

The court below correctly held that the Akron Ordinance's requirement that a woman wait twenty-four hours between the time her physician personally gives her informed consent information and she receives an abortion has a significant impact on a woman's constitutionally protected right to choose abortion, and, therefore, warrants strict judicial scrutiny. Akron Center for Reproductive Health v. City of Akron, 641 F.2d 1198, 1208 (6th Cir. 1981). Far from serving a compelling state interest, which would be necessary to support such a restriction, there is no state interest whatsoever that justifies the mandatory waiting period. Id. Amici, therefore, urge the affirmance of the court of appeals' decision, which is consistent with three

circuits,[38] that a state-mandated waiting period is unconstitutional.

Mandatory waiting periods will inevitably entail delays beyond the statutorily prescribed time. This is caused by a number of factors. First, abortion procedures are not performed every day in most clinics. For example, the Akron clinics perform abortion procedures only three days a week and procedures requiring general anesthesia only once a week.[39] Second, the requirement that

38/ Planned Parenthood of Kansas City v. Ashcroft, 655 F.2d 848, 866 (8th Cir. 1981); Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1980); Charles v. Carey, 627 F.2d 772 (7th Cir. 1980). Accord, Women's Services P.C. v. Thone, 636 F.2d 206, 210 (8th Cir. 1980); Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136 (D.R.I. 1982); Leigh v. Olson, 497 F.Supp. 1340, 1347 (D.N.D. 1980); Margaret S. v. Edwards, 488 F.Supp. 181, 212 (E.D. La. 1980); Women's Health Center v. Cohen, 477 F.Supp. 542, 550 (D. Me. 1979).

39/ Respondents' Consolidated Brief in Opposition to Certiorari at 22.

the attending physician be the one to administer the informed consent information greatly compounds the actual delays involved. While physicians are present every day that abortion procedures are performed, the same physician is not necessarily present each day. A typical pattern at the clinics run by amicus Planned Parenthood Federation of America's (PPFA's) affiliates is for physicians to rotate on a weekly basis.[40] A patient who receives the consent information from her physician would, therefore, have to wait until the following week when he or she returned to duty to have her abortion. The problem would be further complicated by vacation schedules or illness of the attending

40/ Amicus PPFA surveyed its affiliate abortion providers to determine how the Akron Ordinance's attending physician counseling requirement (§ 1870.06(C)) and waiting period (§ 1870.07) would affect clinic practice. Twenty-eight of thirty-nine providers responded to the survey. The information presented here regarding PPFA affiliate clinic practice is based on that survey.

physician [41] and the woman's own school or job schedule

Delaying an abortion even one week is medically unacceptable because the risks to the woman increase dramatically with each week of pregnancy. A woman who cannot obtain an abortion until the tenth week of pregnancy faces a 57% greater risk of suffering from a major complication than she does in the eighth week. The risk of major complications is 91% greater in the eleven to twelve week interval than in the eighth week.[42] The risk of death from abortion increases by 50% with each week of delay.[43]

Another variable that affects abortion morbidity and mortality is the method used to

---

41/ One affiliate reports utilizing seventeen physicians who are on duty once a week over a seventeen week span. See note 40 supra.

42/ Cates, et al., The Effect of Delay and Method Choice on The Risk of Abortion Morbidity, 9 Family Planning Perspectives 266 (1977).

43/ Cates & Tietze, Standardized Mortality Rates Associated with Legal Abortion: United States, 1972-1975, 10 Family Planning Perspectives 109, 111 (1978).

perform the procedure, which changes with gestational age. Vaginal suction curettage or dilatation and evacuation (D & E) procedures performed at earlier stages of gestation are safer than instillation procedures done later.[44/] Indeed, there is evidence that a decline in the number of deaths relating to abortions can be traced partly to performing abortions earlier and using the safer procedures.[45/] A delay that forces a physician to use a less safe abortion procedure is, obviously, contrary to good medical practice and to the interests of preserving health.

Additionally, second trimester procedures are often not as readily available as are abortions performed during the first trimester. Many jurisdictions, including Akron, Ohio, require that

44/ Cates, et al., supra note 42 at 268.

45/ U.S. Dept. of Health and Human Services, Centers for Disease Control, Abortion Surveillance: 1978 9 (1980).

second trimester procedures be performed in a hospital, thus substantially increasing the cost to the woman.[46/] If the state-mandated waiting period delays the abortion into the second trimester, therefore, an abortion may become extremely difficult or impossible to obtain for many women.

Delay can also result in heightened emotional distress for the pregnant woman. In a recent study on attitudes of women receiving abortions towards a mandatory waiting period in Tennessee, 60% of the women surveyed agreed with the statement that "having to wait for the abortion has caused me a lot of added stress and worry

46/ Only one in ten non-Catholic general hospitals offer any second trimester abortions. Henshaw et al., Abortion Services in the United States, 1979 and 1980, 14 Family Planning Perspectives 5, Table 12 (1982). Nationally, in 1978, second trimester dilatation and evacuation (D & E) abortions were two to three times as expensive in hospitals as similar procedures in clinics. Rosoff, The Availability of Second Trimester Abortion Services in the United States 35 in Second Trimester Abortion: Perspectives After a Decade of Experience (Berger, Brenner and Keith eds. 1981).

about my condition." 47/

In addition to the adverse effects on the woman's health, the mandatory waiting period can impose substantial financial burdens. The cost of travel and lost wages is compounded when a woman must return on another day for the abortion procedure. Babysitting costs and the expense of overnight accommodations when the clinic is located far from the woman's home must be added to the financial impact.48/ Extensive travel to reach abortion providers is the rule rather than the

47/ Lupfer & Silber, How Patients View Mandatory Waiting Periods for Abortion, 13 Family Planning Perspectives 75, Table 1 (1981)

48/ In the survey of Tennessee abortion patients, where the women typically lived 80 miles from the urban center where the clinic was located, 59% reported having to bear additional travel expenses. Forty-one percent of those surveyed reported losing wages because of the waiting period; the median loss was $32. Forty-five percent of the women were mothers with young children; 22% of these had to pay for additional child care because of the waiting period. Id. at 77.

exception in the United States, especially for rural women. Almost 70% of women living in non-metropolitan areas live in counties with no facility reporting even one abortion and 95% live in counties without a provider reporting 400 or more abortions a year.[49/] Perhaps the most serious financial burden will be the added cost, which the clinics will have to pass on to the patients, arising from the need to schedule the woman for two visits with a physician.[50/]

Amici strongly support the practice of affording a woman sufficient time to make a thoughtful and knowledgeable decision regarding the abortion. In fact, PPFA abortion providers typically schedule pregnancy testing and counseling on a different day from surgery.[51/]

49/ Henshaw et al., supra note 46 at 10.

50/ See text surrounding notes 29 through 32 supra.

51/ See note 40 supra.

However, two crucial factors distinguish this common provider practice from the mandatory scheme imposed by the Akron Ordinance. First, at Planned Parenthood abortion clinics the informed consent counseling is typically performed by a trained non-physician counselor. Thus, the difficulties in attempting to schedule two visits with the physician who performs the abortion are avoided and actual delay and financial impact are minimized; abortions can, in reality, occur twenty-four hours after counseling. Second, and perhaps most crucial, such practice is not inflexible. PPFA affiliate abortion providers which serve rural populations will typically provide a "same day" service to accommodate woman who must travel far to receive their abortions.[54/] Thus, the fault in grafting

54/ For example, at one affiliate which provides such a service, 55% of the clients travel fifty miles or more to the clinic which is the only first trimester outpatient abortion facility in eight counties.

what may be generally good medical practice onto the criminal law is the straitjacket it applies to physicians' ability to tailor practice to the needs of the individual patient. See, Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 76. n.8. (1976).

Amici have shown that the waiting period is not only a direct obstacle to the woman's decision to obtain an abortion, but will also result in substantial medical, emotional and financial harm for many women. Such a restriction must be held invalid, therefore, as to the first trimester of pregnancy, when no state interests can justify such intrusion. 651 F.2d at 1208. Moreover, the harm inflicted upon women by this provision directly conflicts with the sole compelling state interest which this Court has identified as arising at the end of the first trimester of pregnancy and prior to fetal viability -- the health of t woman. Roe v. Wade, 410 U.S. 113, 163 (1973). Even if a waiting period could be justified

in principle by the rationale offered by Akron and rejected by the Court of Appeals as "the insurance that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation," 651 F.2d at 1208, the mandatory and inflexible requirement of the Ordinance is hardly narrowly tailored to serve that interest. 410 U.S. at 163. Courts have consistently found that women carefully consider their decision to terminate a pregnancy before their first visit to a clinic. Planned Parenthood League of Mass. v. Bellotti, 641 F.2d at 1015; Women's Community Health Center v. Cohen, 477 F.Supp. at 551; Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft, 483 F.Supp. at 696, affirmed 655 F.2d 848 (8th Cir. 1981). The Tennessee study discovered that the vast majority (88%) of women discussed the decision to obtain an abortion with at least one other person before speaking to a counselor at a clinic. Most commonly the other person was the woman's partner or

a close friend.[53] In a second Tennessee survey, conducted at the close of the waiting period, the majority of the women (55%) disagreed with the statement that "the required waiting period has been beneficial because it has given me time to think to be sure I was doing the right thing."[54]

The waiting period imposed by the Ordinance is a mandatory, inflexible requirement that will result in delay beyond the 24-hour limit and will increase the health risks and financial burdens to the patient. As there is no state interest, compelling or otherwise, that justifies these burdens, *amici* ask that this Court hold the waiting period unconstitutional.

53/ Lupfer & Silber, *supra* note 47 at 76.

54/ *Id.* at Table 1. 82% of the women felt they had carefully thought about the morality of abortion before approaching the clinic and did not need the waiting period to consider it further. *Id.*

IV SECTION 1870.03 OF THE AKRON ORDINANCE, REQUIRING THAT ALL POST-FIRST TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONAL BECAUSE IT IS NOT A REASONABLE MEANS OF PROTECTING MATERNAL HEALTH

Amici urge reversal of the court of appeals' ruling that section 1870.03 of the Akron Ordinance is constitutional. The court of appeals found "persuasive" the argument that requiring all post-first trimester abortions to be performed in hospitals was not a reasonable means of protecting maternal health, 651 F.2d at 1210, but declined to hold the Ordinance invalid because it felt bound by this Court's summary affirmance in Gary Northwest Indiana Women's Services v. Bowen, 496 F.Supp 894 (N.D. Ohio 1980), affirmed, _____U.S. _____, 101 S.Ct. 2012, 68 L.E .2d 321 (1981). Amici support Cross-Petitioners' position that the court below erred in according Gary-Northwest absolute precedential value and should have declared section 1870.03 unconstitutional based on the evidence before it.

PPFA and other of the amici have already filed a brief on the health

aspects of requiring that all post-first trimester abortions be performed in hospitals in another case pending before this Court, Planned Parenthood Association of Kansas City, Mo. v. Ashcroft, Nos. 81-1255 and 81-1623. Because of space limitations, amici refer the Court to the argument at pages 13 through 42 of that brief.

Amici's brief in the Ashcroft case demonstrated, inter alia, that a hospitalization requirement severely burdens women's access to second trimester abortions because few hospitals provide such services. Since filing the brief, amici have been able to obtain data on the national availability of dilatation and evacuation (D & E) abortions in hospitals. (It is this method of abortion which Cross-Petitioners argue can safely be performed in clinics).

The Alan Guttmacher Institute surveyed a random sampling of second-trimester hospital abortion providers in the United States and found that only eleven percent performed as many as one D & E procedure

per week.[55] Putting these figures into the context of the general unavailability of hospitalized second trimester abortion services, fewer than one percent (.79%) of general short term non-Catholic hospitals perform as many as one D & E procedure a week.[56] Requiring that all post-first trimester abortions be performed in hospitals, thus, seriously undercuts the availability of these services to pregnant women.

55/ D & E procedures were defined for the purposes of the survey as those performed past the fourteenth week since the first day of the woman's last menstrual period.

56/ Memorandum from Dr. Stanley Henshaw, Senior Research Associate, the Alan Guttmacher Institute (AGI), New York, NY to Dara Klassel, Staff Attorney, Planned Parenthood Federation of America (August 20, 1982). The memorandum is reproduced in Appendix A. The AGI annually collects data on abortion providers. AGI statistics have, since 1975, been accepted by the Census Bureau as the official statistics on abortion in the United States and are published each year in the U.S. Government Statistical Abstract.

V. SECTION 1870.05 (B) OF THE AKRON ORDINANCE, REQUIRING PARENTAL OR JUDICIAL CONSENT TO MINORS' ABORTIONS, PERMITS AN UNCONSTITUTIONAL VETO OF A MINOR'S ABORTION CHOICE

The court of appeals affirmed the district court's holding that § 1870.05 (B) of the Akron Ordinance delegates an impermissible veto to third parties to deny even a mature minor's abortion request. 651 F.2d at 1205, affirming 479 F.Supp at 1201.[57/] Amici support this holding and urge affirmance of the court of appeals.

Section § 1870.05 (B) of the Ordinance provides that no physician may perform an abortion on a minor under fifteen years old without

> (1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or
>
> (2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

This requirement directly contravenes this Court's holding in Bellotti v. Baird, 443 U.S. 622 (1979), that any judicial alternative to mandatory parental

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57/ Amici also fully support Cross-Petitioners' argument that no party had standing to appeal this issue to the court of appeals or to this Court and that Ohio law fails to provide a viable judicial alternativ to parental consent.

involvement in a minor's abortion decision must grant a minor the right to demonstrate to the court that she is mature enough to make the abortion decision independently and, if found to be mature, to have the court grant her request for an abortion. Id. at 643-44. This Court was quite explicit in holding that any statute that gives a presiding judge the discretion to overrule a mature minor's decision is invalid. Id. at 650. See also, id. at 652 (Stevens, J., concurring). The Akron Ordinance, containing no standards for judicial approval or disapproval of a minor's abortion request, utterly fails to guarantee this right of choice to the mature minor.

Amici strongly take issue with Respondent-Intervenors' argument that the state may properly treat all minors under fifteen as immature.[58/] This Court rejected any such approach in Bellotti.

> The nature of both the State's interest in fostering parental authority and the problem of determining "maturity" makes clear why the State generally may resort to objective, though inevitably

58/ Brief of Respondents Francois Seguin, M.D. and Patricia K. Black at 21.

> arbitrary, criteria such as age limits... for lifting some or all of the legal disabilities of minority. Not only is it difficult to define, let alone determine, maturity, but the fact that a minor may be very much an adult in some respects does not mean that his or her need and opportunity for growth under parental guidance and discipline have ended. As discussed in the text, however, the peculiar nature of the abortion decision requires the opportunity for case-by-case evaluations of the maturity of pregnant minors.

Id. at 643 n.23 (emphasis added). The "peculiar nature" of that decision includes the burdens of premature parenthood on young lives and the "grave and indelible" consequences of denying the minor the right to choose whether or not to carry a pregnancy to term. Id. at 642.

For all of these reasons, amici request that this Court affirm the court of appeals decision with regard to section 1870.05 (B).

CONCLUSION

For all the foregoing reasons, amici request that the Court of Appeals' judgment with respect to §§ 1870.05(B), 1870.06(B) and (C) and 1870.07 of the Akron Ordinance be affirmed and that the judgment with respect to §1870.03 be reversed.

Respectfully submitted,

EVE W. PAUL
DARA KLASSEL
PAULA SCHAAP

Planned Parenthood Federation
of America, Inc.
810 7th Avenue
New York, New York 10019
(212) 541-7800

Attorneys for Amici Curiae

August, 1982

Amici wish to acknowledge the assistance of Helen Kloogman, a student at the National Law Center, the George Washington University, in the preparation of this brief.

The Alan Guttmacher Institute

A Corporation for Research, Policy Analysis and Public Education

360 Park Avenue South
New York, New York 10010
Telephone 212 685-5858

MEMORANDUM

August 20, 1982

TO: Dara Klassel, Staff Attorney, PPFA
FROM: Stanley K. Henshaw, Ph.D., Senior Research Associate
RE: D & E abortion services in hospitals

s/ Stanley K. Henshaw

In July and August, 1982, The Alan Guttmacher Institute (AGI) surveyed 40 hospitals randomly selected from among those hospitals listed in the AGI survey of all U.S. abortion providers as having provided 10 or more second-trimester abortions in 1980. (The AGI data on the number of second-trimester procedures performed is based on the facilities' own definitions of "second-trimester." For some hospitals, however, state health department data on gestation were used; for these hospitals, abortions past 12 weeks LMP were regarded as second-trimester procedures.)

Of the 40 hospitals surveyed, two no longer perform second-trimester abortions and two refused to provide the necessary information. Of the remaining 36 hospitals, 19 percent (seven hospitals) reported that D & E procedures past 14 weeks LMP (weeks since the onset of the last menstrual period) are performed in their facilities. (At least six other hospitals provide abortions at 13-14 weeks but not past 14 weeks.) Of these, three hospitals perform fewer than one D & E procedure a week, leaving only 11 percent of the hospitals (four hospitals) performing as many as one D & E a week.

Therefore only about 11 percent of hospitals where 10 or more second-trimester abortions were performed in 1980 provide D & E abortions past 14 weeks LMP. Since 26.5 percent of all hospital abortion providers reported 10 or more second-trimester abortions in 1980, only 2.9 percent of hospital abortion providers perform as many as one D & E a week. Only a minority of all U.S. hospitals (27 percent) offer any abortion services, however; therefore less than one percent (0.79 percent) of all non-Catholic short-term general hospitals perform as many as one D & E a week.

APPENDIX A

Nos. 81-746 and 81-1172

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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

CITY OF AKRON, et al.,

Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,

Petitioners,

—v.—

CITY OF AKRON, et al.,

Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF *AMICUS CURIAE* OF CERTAIN RELIGIOUS ORGANIZATIONS

RHONDA COPELON
c/o Center for Constitutional Rights
853 Broadway
New York, NY 10003
(212) 674-3303

Attorney for *Amici Curiae.*

TABLE OF CONTENTS

TABLE OF CASES.....iii

INTEREST OF THE AMICI.....2

QUESTIONS PRESENTED.....4

SUMMARY OF ARGUMENT.....5

ARGUMENT.....8

POINT I: THIS COURT IS DUTY-BOUND TO GIVE STRICT SCRUTINY TO STATUTES THAT IMPINGE THE EXERCISE OF FUNDAMENTAL RIGHTS.....8

POINT II: CHAPTER 1870 VIOLATES THE FIRST AMENDMENT'S PROHIBITION OF STATE SPONSORSHIP OF BELIEF.....16

POINT III: CHAPTER 1870 VIOLATES THE RELIGION CLAUSES OF THE FIRST AMENDMENT IN THAT IT INFRINGES THE FREE EXERCISE OF RELIGION AND TAKES SIDES IN A CONFLICT OVER RELIGIOUS PRINCIPLE...32

A. Chapter 1870 Violates The Right To Make And Effecuate A Conscientious Decision Concerning Abortion In Violation Of The Free Exercise Clause.....33

B. Chapter 1870 Discriminatorily Burdens Both Women For Whom Abortion Is A Religious Decision of Conscience And Doctors Who Assist Them, In Violation Of The Obligation of State Neutrality Commanded By The Free Exercise Clause.....42

C. Chapter 1870 Constitutes State

Sponsorship of One Religious
Belief In Violation Of The
Establishment Clause Of
The First Amendment.....49

TABLE OF CASES

Cases: Page

Akron Center for Reproductive Health, Inc, v. City of Akron, 651 F.2d 1198 (6th Cir. 1981)...1

Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. 1172 (N.D. Ohio 1979).....1

Ballard v. United States, 322 U.S. 78 (1944).....47

Braunfeld v. Brown, 366 U.S. 599 (1961).....45

Brown v. Board of Education, 347 U.S. 438 (1954).....12

Canterbury v. Spence, 464 F.2d 772 (1972), cert. den. 409 U.S. 1064 (1972).....29

Committee for Public Education v. Nyquist, 413 U.S. 756 (1973)....54

Elrod v. Burns, 427 U.S. 347 (1976).....19

Engel v. Vitale, 370 U.S. 421 (1962).....12, 49, 54

Everson v. Board of Education, 330 U.S. 1 (1947).....44, 50, 55,58

Federal Communications Commission v. Pacifica, 438 U.S. 726 (1978).....24

Fowler v. Rhode Island, 345 U.S. 67 (1953).....47

Gillette v. United States, 401 U.S. 437 (1971).....35, 45

Griswold v. Connecticut, 381 U.S. 479 (1965).....23

Harris v. McRae, ___U.S.___, 100 S.Ct. 2371 (1980).....36, 37, 41, 48, passim

Jacobson v. Massachusetts, 197 U.S. 11 (1905).....48

Kovacs v. Cooper, 336 U.S. 77 (1949).....24

Lehman v. City of Shaker Heights, 418 U.S. 298 (1974).....24

Leigh v. Olson, 497 F. Supp. 1340 (S.D. No. Dak. 1980).....20, 21

Maher v. Roe, 432 U.S. 464 (1977).....37, 41, 44

Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803).....6, 16

Margaret S. v. Edwards, 488 F.Supp 18 (E.D. La.).....21

Martin v. City of Struthers, 319 U.S. 141 (1943).....23

McDaniel v. Paty, 435 U.S. 618 (1978).....34, 41

McGowan v. Maryland, 366 U.S. 420 (1961).....52

McRae v. Califano, 491 F. Supp. 630 (E.D.N.Y. 1980) rev'd sub nom. Harris v. McRae 100 S.Ct. 2671 (1980).....35, 36

Murdock v. Pennsylvania, 319 U.S. 105 (1943).....46

Niemotko v. Maryland, 340 U.S. 268 (1951).....46

Olmstead v. United States, 277 U.S. 438 (1928).....14

People ex rel. McCollum v. Board of Education, 333 U.S. 203 (1948).....53, 54

Planned Parenthood League of Massachusetts v. Belloti, 641 F.2d 1006 (1st Cir. 1981).....20, 21

Planned Parenthood v. Danforth, 428 U.S. 52 (1976).....29, 30

Planned Parenthood of Kansas City Missouri v. Ashcroft, (No. 81-1255, 81-1623).....1

Prince v. Massachusetts, 321 U.S. 158 (1944).....47

Public Utilities Commission v. Pollak, 343 U.S. 451 (1952)....24

Roe v. Wade, 410 U.S. 113 (1973).....4,5,7, 18, passim

School District of Abington v. Shempp 374 U.S. 203 (1963).....13, 49, 54

Scopes v. State, 154 Tenn. 105, 289 S.W. 363 (1927).....51

Sherbert v. Verner, 374 U.S. 398 (1963).....37, 44, 45, 47

Simopolos v. Virginia (No. 81-185).....1

Stanley v. Georgia, 394 U.S. 557 (1964).....23

Stone v. Graham, ___U.S.___, 101 S.Ct. 192 (1981).....54

Swann v. Charlotte Mecklenberg Board of Education, 402 U.S. (1971).....12

Thomas v. Review Board, ___U.S. ___, 101 S.Ct. 1425 (1981).....34, 37

Torasco v. Watkins, 367 U.S. 488 (1961).....22, 34

United States v. Seeger, 380 U.S. 163 (1965).....35, 46, 52

Walz v. Tax Commission of the City of New York, 397 U.S. 664 (1970).....45, 50

Welsh v. United States, 398 U.S. 333 (1970).....35, 46

West Virginia State Board of Education v. Barnette, 319 U.S. 624 (1943).....11, 19, 26, 27, passim

Wisconsin v. Yoder, 406 U.S. 205 (1972).....34, 40

Wolman v. Walter, 433 U.S. 229 (1977).....51

Wooley v. Maynard, 430 U.S. 705 (1977).....19

Statutes:

First Amendment, United States Constitution.....4, 6, 7, 8, passim

H.J. Res. 30, 823, 856, 858 92d Cong. 2d. Sess. (1957).....12

H.J. Res. 191 (1971).....13

H.J. Res. 1035, 92d Cong. 2d. Sess. (1972).....12

H.R. 1228, 85th Cong., 1st Sess. (1957).....12

H.R. 13915, 13916, 92d Cong., 2d Sess. (1972).....12

Ohio Rev. Code Ann ¶4731.91.....43

S.3467, 85th Cong., 2d Sess. (1958).....12

S.J. Res. 165, 92d Cong., 1st Sess. (1971).....12

Other Authorities:

Eisenberg, "Congressional Authority to Restrict Lower Federal Court Jurisdiction, 83 Yale Law Journal 498 (1974).....13

The Human Life Bill: Hearings on S.158 Before the Subcommittee on Separation of Powers of the Senate Committee on the Judiciary, 97th Cong., 1st Sess. (1981).....31

The Human Life Bill - Appendix: Hearings on S.158 Before the Subcommittee on Separation of Powers of the Senate Committee on the Judiciary, 97th Cong., 1st Sess. (1981).....31

The Human Life Bill - S.158: Report, together with Additional and Minority Views to the Committee on the Judiciary made by its Subcommittee on Separation of Powers, 97th Cong., 1st Sess. (1981).....31, 53

Tillich, The Shaking of the Foundations (1948).....52

BRIEF AMICUS CURIAE OF CERTAIN RELIGIOUS ORGANIZATIONS

This brief amicus curiae is filed in support of the plaintiffs below in City of Akron v. Akron Center for Reproductive Health, Inc., et al.,* by the following religious organizations: AMERICAN ETHICAL UNION; AMERICAN HUMANIST ASSOCIATION; CATHOLICS FOR A FREE CHOICE; COORDINATING CENTER FOR WOMEN IN CHURCH AND SOCIETY; UNITED CHURCH OF CHRIST; NATIONAL BOARD, YOUNG

* The views expressed by amici herein are equally relevant to the issues before the Court in Planned Parenthood of Kansas City Missouri, Inc v. Ashcroft, (Nos. 81-1255, 81-1623), and Simopolos v. Virginia (No. 81-185). Amici have chosen to file in this case because the effort to sponsor and impose belief in violation of the First Amendment which underlies all the abortion restrictions before this Court, is most explicit in the Akron ordinance.

WOMEN'S CHRISTIAN ASSOCIATION OF THE U.S.A.; NATIONAL COALITION OF AMERICAN NUNS; NATIONAL FEDERATION OF TEMPLE SISTERHOODS; NORTH AMERICAN FEDERATION OF TEMPLE YOUTH; OFFICE FOR CHURCH IN SOCIETY, UNITED CHURCH OF CHRIST; UNION OF AMERICAN HEBREW CONGREGATIONS; UNITARIAN UNIVERSALIST ASSOCIATION; UNITARIAN UNIVERSALIST WOMEN'S ASSOCIATION; UNITED CHURCH BOARD FOR HOMELAND MINISTRIES; UNITED SYNAGOGUE OF AMERICA; WOMEN'S DIVISION, GENERAL BOARD OF GLOBAL MINISTRIES, UNITED METHODIST CHURCH; and WOMEN'S LEAGUE FOR CONSERVATIVE JUDAISM.

INTEREST OF THE AMICI

The organizations joining this brief are representatives of Protestant, Catholic and Jewish faith, reflecting a broad spectrum of

religious believers in this country. These organizations also reflect a broad spectrum of beliefs about the morality of abortion.* Among the amici are denominations which adhere to religious principles that permit, counsel, and even mandate abortion under certain circumstances. Others strongly discourage it under many circumstances. But all believe that the abortion decision is a deeply religious and personal one of ultimate dimension which must be confided to the conscience of the individual woman free of governmental interference or coercion. They believe further that the effort to restrict abortion

* The positions of the Religious Coalition for Abortion Rights and 32 of national religious organizations which favor the right to choose abortion among which are the amici curiae are contained in the Appendices A & B respectively at a-1 and a-3.

is rooted in an opposing theological position concerning the creation of human life and the beginning of human pershonhood; and that in the face of religiously-based moral differences government in a free society is without power to take sides. Amici submit that the freedom of belief guaranteed by the first amendment and the unitary principle of church-state separation require invalidation of this legislation which has no purpose and effect other than to encroach upon and ultimately deny the right that is the cornerstone of our constitution--the right of conscience.

QUESTIONS PRESENTED

1. Whether the standard of strict scrutiny applied in Roe v. Wade must be applied here to fulfill this Court's duty under Article III and the Bill of Rights

to guard fundamental rights against legislative infringement.

2. Whether Akron Ordinance, Chapter 1870 violates the first and fourteenth amendments' prohibition on governmental coercion to believe, espouse belief, or act in accordance with state-sponsored belief.

3. Whether the Ordinance violates the religion clauses of the first and fourteenth amendments in that it interferes with the free exercise of religion and conscience in the abortion decision and sponsors one theological perspective on abortion in the face of profound conflict over religiously-grounded moral principles concerning the creation and sanctity of life.

SUMMARY OF ARGUMENT

Since Roe v. Wade, no case before the

Court has presented, more explicitly or pointedly than this one, the nature and scope of constitutional rights at stake in the abortion cases.

The Solicitor General's contention that this Court should dilute its standard of review and defer to the legislature whenever a fundamental right is in controversy advocates a shocking and dangerous departure from the principle fundamental to our constitutional scheme that it is the "province and duty of the judicial department to say what the law is." Marbury v. Madison, 5 U.S. (1 Cranch), 137, 176 (1803), and to protect the rights of the individual against majoritarian disapproval and excess.

This particular ordinance illustrates as well the impermissibility of abortion restrictions under the First Amendment.

The first amendment's shelter for the realm of intellect and spirit denies to the state the power to require individuals to espouse or to listen to beliefs they do not hold or information they deem false or misleading. The first amendment likewise protects against being induced or forced to act according to morally offensive beliefs. By requiring espousal of and seeking to induce conformity to the belief that human life begins at conception, the ordinance violates the first amendment. it also underscores that the decision in Roe v. Wade, which denied to civil authority the power to adopt a "theory of life," was compelled not only by the fourteenth but also the first amendment.

Finally, because the controversy over abortion involves competing moral viewpoints rooted in theological differences, the ordinance violates the

religion clauses of the first amendment. It interferes ideologically and practically with a woman's right to freely exercise her religion and conscience in making the abortion decision, while placing no similar obstacles in the path of the woman whose faith compels childbirth. Because the state-sponsored view that human life begins at conception is intrinsically and identifiably theological, the ordinance departs from the rigorous neutrality required where competing religious claims are at stake.

POINT I. THIS COURT IS DUTY BOUND TO GIVE STRICT SCRUTINY TO STATUTES THAT INFRINGE THE EXERCISE OF FUNDAMENTAL RIGHTS.

Amici had intended to address their brief entirely to the first amendment aspects of the Akron ordinance.

However, the brief filed recently by the Solicitor General of the United States suggests so radical and dangerous a departure from our constitutional scheme that a brief response is required.

The Solicitor's argument that the Court should dilute the constitutional standard for reviewing restrictions on abortion* is inseparable from his contention that legislatures on every level, and not the Court, should determine what rights are fundamental and

* In Point I, the Solicitor attempts to dilute the compelling state interest test by making it contingent on a showing that the regulation at issue is "unduly burdensome." This Court's consistent application of strict scrutiny by transforming into a threshold for scrutiny terms the Court has used to describe the result of its constitutional analyses. The affect of this dangerous play on words is to insulate a potentially vast, wavering, and subjective area from judicial review. Not only would this deeply threaten the protection which the Bill of Rights guarantees to fundamental personal rights; it would also undermine the predictability of judicial decision and, thereby, generate not less but more legislation curtailing such rights and, accordingly, more cases requiring plenary review in this Court.

the extent to which they will be protected.* Essentially, the Solicitor is calling for this Court to abdicate its constitutional function as guardian of individual and civil rights.

Similar arguments have been heard in this Nation during periods when constitutional rights were under attack. One of the most eloquent responses to the argument for legislative deference was made by Justice Jackson, in a case which is, at its heart, very similar to this one:

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no election.

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* See Brief of the United States, Point II generally.

West Virginia State Board of Education v. Barnette, 319 U.S. 624, 638 (1943).

To the argument that the Court lacked competence to protect fundamental rights in the face of competing policy considerations, he replied:

> ...[W]e act in these matters not by authority of our competence but by force of our commissions. We cannot because of our modest estimates of our competence in such specialties as public education, withhold the judgment that history authenticates as the function of this Court when liberty is infringed.

id. at 639-40.

The contention that the Court should defer to the legislatures on the matter of fundamental rights threatens every guarantee of the Bill of Rights. All constitutional rights, whether explicit or implicit, are necessarily defined and shaped by this Court's interpretation of constitutional principle. This includes

rights so fundamental as the right to be free of racial segregation, Brown v. Board of Education, 347 U.S. 483 (1954), or of state sponsorship of religious exercises in the schools, Engel v. Vitale, 370 U.S. 421 (1962). With each one of these decisions and with countless others the Court has faced and survived powerful pressures from political movements opposed to the constitution's guarantee of these fundamental rights.*

* For example, in response to Brown v. Board of Education, its opponents sought to withdraw Supreme Court and lower federal court jurisdiction from school desegregation cases. See, e.g. HR 1228, 85th Cong., 1st Sess. (1957), and S 3476, 85th Cong., 2d Sess (1958). Likewise, after the decision in Swann v. Charlotte Mecklenberg Board of Education, 402 U.S. 1 (1971), opposition was marshalled in the form of both constitutional amendments, see, e.g. H.J. Res 1035, 92d Cong. 2d. Sess. (1972), S.J. Res. 165, 92d Cong., 1st Sess. (1971), H.J. Res. 30, 823, 856, 858, 92d Cong, 1st Sess. (1971); and bills, which received the backing of the Nixon administration, see H.R. 13915, 13916, 92d Cong., 2d Sess. (1972). In the area of school prayer, efforts to circumvent the impact of this Court's decisions in Engel v. Vitale, 370 U.S.

(footnote continued on next page)

The right to privacy which embraces the right to abortion is not, as the Solicitor suggests at one point,* less deserving of this Court's rigourous protection because it is implicit in the Bill of Rights. It is, in fact, the foundation of human capacity to exercise all the rights guaranteed

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(footnote continued from preceding page)

421 (1961) and School District of Abington v. Schemp, 374 U.S. 203 11963) have included numerous constitutional amendments. See, e.g. the Becker Amendmemnt (1964), the Dirksen amendments (1966, 1967), and the Wylie amendment (H.J. Res. 191, 1971).

Similarly, this Court's decisions in the areas of reapportionment and citizen protection from legislative investigation, have been opposed by legislative attempts to limit the Court's jurisdiction. See Eisenberg, "Congressional Authority to Restrict Lower Federal Court Jurisdiction," 83 Yale Law Journal 498 (1974).

* Brief for the United States at 20-21.

in a democracy. As Justice Brandeis wrote:

> The makers of our constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone -- the most comprehensive of rights and the right most valued by civilized man.

Olmstead v. United States, 277 U.S. 438, 487 (1928) (Brandeis, J., dissenting).

Periodically, this nation and our constitution are threatened by religious and ideological forces which seek safety in conformity, and efficacy through coercion. In such times as these when legislatures are under extreme pressure to undo the Bill of

Rights, the Court, as the ultimate guardian of the liberties fundamental to a democracy, is inevitably under attack as well. But the integrity of the Court, the survival of our constitutional system, and the guarantee of individual liberty are preserved, not by acquiescence to these pressures, but by solemn and unswerving fulfillment of the duty conferred upon this Court by the written constitution.

In sum, the Solicitor challenges the most fundamental principle of the constitutional scheme of checks and balances -- that it is "the province and duty of the judicial department to say what the law is," to declare that "an act of the legislature, repugnant to the consituation is void," and to guarantee that when rights are violated, the "individual has a right to resort to the laws of his country

for a remedy." Marbury v. Madison, 5 U.S. (1 Cranch) 137, 176, 166. This Court has no higher office under the constitution than to protect individual rights under challenge.

Under any standard of review under the fourteenth amendment, Chapter 1870 must be invalidated. But the protection of the right to abortion, like that of all fundamental constitutional rights, properly calls for undiluted application of strict judicial scrutiny.

POINT II. CHAPTER 1870 VIOLATES THE FIRST AMENDMENT"S PROHIBITION ON STATE SPONSORSHIP OF BELIEF.

At the heart of the ordinance at issue are several provisions which the City of Akron has implicitly conceded to be unconstitutional.

¶1870.06(B)(3)(4) and (5).* This concession does not remove these matters from the Court's purview, but rather underscores the unconstitutionality of the remaining sections.** It also brings into sharp focus the first amendment underpinnings of this Court's refusal to allow civil government to adopt "a theory of life" to override a woman's right

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* Brief for City of Akron at 33-37.

** The preamble makes clear that the purpose of the ordinance is to advance the belief that human life begins at conception:

> It is the finding of council that there is no point in time between union of sperm and egg, or at least the blastocyst stage and the birth of the infant at which point we can say the unborn child is not a human life, and that the changes occurring between implantation, a six-weeks embryo, a six-month fetus, and a one-week-old child, or a mature adult, are merely stages of development and maturation....

While other clauses of the preamble recite an interest in the health of the woman, the record demonstrates that the provisions purportedly serving that end are not simply unnecessary but actually increase abortion. See, respondents-cross-petitioners' brief generally.

to abortion. Roe v. Wade, 410 U.S. at 162.

The concededly unconstitutional sections require that the doctor tell a woman that "the unborn child is human life," describe fetal characteristics and functions associated with the particular stage of gestation, and tell her that the "unborn child" may be viable if over 22 weeks, and that abortion is a major surgical operation which can produce serious physical complications or emotional disturbances. Related sections prohibit performance of the abortion for at least 24 hours, ¶1870.07 and require the doctor to advise her of prenatal adoption services, ¶¶1870.06(7) and of the particular risks associated with her own pregnancy and abortion, ¶1870.06(C). A doctor who performs an abortion without observing these conditions is subject to criminal penalties, ¶1870.18(A).

It is axiomatic that the state cannot, consistent with the first amendment, use its citizens to propagandize certain beliefs. Invalidating the compulsory flag salute in West Virginia State Board of Education v. Barnette, the Court held:

> We think the action of the local authorities in compelling the flag salute and pledge transcends constitutional limitations on their power and invades the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from all official control.

319 U.S. at 642. More recently, in Wooley v. Maynard, the Court held that "freedom of thought ... includes both the right to speak freely and the right to refrain from speaking at all," 430 U.S. 705, 714 (1977) and protected the right of individuals not to bear an ideological message which they find "morally objectionable." id. at 715. See also, Elrod v. Burns, 427 U.S. 347 (1976).

(Public employment cannot generally be conditioned on affiliation with a particular political party.)

Here the message that "the unborn child is human life" expresses a belief that is morally objectionable to many. Roe v. Wade, 410 U.S. at 117. The description of fetal characteristics has no purpose other than the support of this belief.* In striking a fetal description requirement on first amendment grounds, the Circuit Court in Planned Parenthood League of Massachusetts v. Bellotti recognized that the "primary purpose of the required information is not so much factual as it is moral." 641 F.2d 1006, 1022 (1st Cir. 1981).

* The required description of fetal development is not relevant to protecting maternal health. Rather it is designed to support the belief that the fetus is human life and increase the stress of the woman undergoing abortion. See, Planned Parenthood of Massachusetts v. Bellotti, 641 F.2d 1006, 1021-2 (1981), Leigh v. Olson, 497 F. Supp. 1340, 1345 (S.D. No. Dak. 1980).

The court drew the line between permissible and impermissible coercion of information-giving under the first amendment:

> To the extent that information may be imposed by the state, it must be neutral and objective; coercive state indoctrination of particular values or ethical judgments is objectionable to First as well as Fourteenth Amendment principles. The state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of a fundamental right.

Id. at 1022. See also, Planned Parenthood of Mass. v. Bellotti, 641 F.2d 1006-1002 (1981), Margaret S. v. Edwards, 488 F. Supp. 181, 208-209 (E.D. La. 1980), Leigh v. Olson, 497 F. Supp. 1340, 1345.

The remaining information about medical risks and adoption alternatives requires the doctor to give false, misleading or

patently irrelevant information. These provisions also serve, not to ensure an informed decision, but again to support, in blatant and subtle ways, the underlying contention that abortion is immoral.*

Moreover, these sections require the doctor to communicate information he or she does not believe to be truthful let alone objective in nature. While there is no case on point in the annals of this Court, the freedom of thought and expression shielded by the first amendment must surely extend protection against state-enforced compulsion to lie or mislead. See Torasco v. Watkins, 367

* For example, although there are some cases where a doctor or counselor will discuss the alternative of adoption, to mandate that information, which is irrelevant in most cases, implicitly carries the message that the state views abortion as morally objectionable. Likewise ¶1870.06(C), which mandates description of the risks of abortion, but not of its alternatives, is particularly distorting given that abortion is the safer medical alternative.

U.S. 488, 494 (1961) cf. (first amendment prohibits limiting public office to those who have or profess belief in certain religious concepts).

The first amendment rights of pregnant women are also violated by this mandated consent and waiting process. Just as the first amendment guarantees a right to listen and receive information, see e.g., Stanley v. Georgia, 394 U.S. 557, 564 (1964) (right to read obscenity in one's house); Martin v. City of Struthers, 319 U.S. 141, 143, (1943) (right of colporteurs to distribute religious literature) it must guarantee its corollary--the right not to be forced to listen. Cf. Griswold v. Connecticut, 381 U.S. 479, 482-84 (1965) (penumbras of first amendment include many rights not specifically articulated). Thus, the Court has recognized protection against unwanted intrusion and objectionable messages for the "captive audience." See e.g. Federal

Communications Commission v. Pacifica, 438 U.S. 726 (1978) (upheld regulation of "offensive" material on radio); Kovacs v. Cooper, 336 U.S. 77 (1949) (sustained ordinance regulating sound trucks); cf, Lehman v. City of Shaker Heights, 418 U.S. 298 (1974) (upheld transit system's right not to take paid political advertising), Public Utilities Commission v. Pollak, 343 U.S. 451 (1952) (permitted radio music on busses because it contained no propaganda).

These cases indicate that the constitution intervenes to protect against forced listening where the invasion of privacy and the captivity of the audience is far less severe than it is under the Akron ordinance. By making the doctor a mouthpiece of the state, the sanctity of a woman's decision-making process is invaded. Unlike the radio listener who can decide

not to listen to a particular channel, the pregnant woman cannot refuse the information or affect the doctor's obligation to give it to her unless she sacrifices her right to abortion.

Moreover, by forcing her to wait 24 hours, no matter how certain she is or how fully informed her decision, the City not only concretely impedes her right to abortion but also underscores its moral disapproval of her decision.

As there is little more offensive to the notion of a free people than compulsion to speak or compulsion to hear morally objectionable and one-sided messages, the standard by which this ordinance must be judged under the first amendment is the strictest. As the Court held in Barnette:

> Censorship or suppression of expression or opinion is tolerated by our constitution only when the expression presents a clear and present danger of action of a kind

> which the state is empowered to prevent and punish. It would seem that involuntary affirmation could be commanded only on even more immediate and urgent grounds than silence.

319 U.S. at 633 (emphasis supplied). These provisions which propagandize the belief that human life begins at conception, bring into focus the impermissibility of the remaining provisions of the ordinance as well as the wisdom of the decision in Roe v. Wade, 410 U.S. 113 (1973).

In Roe v. Wade, this Court emphasized the theological and metaphysical nature of the underlying question of when life begins:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.

410 U.S. at 159. The refusal to allow the state to "adopt a theory of life" to override a woman's right to abortion was, like the refusal to allow the flag salute in Barnette, an affirmation of the individual's freedom to believe and to follow one's beliefs as well as of the absence of power in the state to sponsor a contrary civil or religious faith.

Moreover, this is not a case where competing policy considerations, otherwise within the realm of legislative power, must be inhibited to protect a fundamental right. Abortion is a matter which involves competing claims based on divergent moral beliefs as to which the first amendment's guarantee of freedom of expression prohibits the state from taking sides. As the Court held in Barnette:

> Struggles to coerce uniformity of sentiment in support of some end thought essential to their time

have been waged by many good as well as evil men: Nationalism is a relatively recent phenomenon but at other times and places the ends habe veen racial or territorial security, support of a dynasty or regime and particular plans for saving souls. ...Those who begin the coercive elimination of dissent soon find themselves exterminating dissenters. Compulsory unification of the opinion achieves only the unanimity of the graveyard Nationalism is a relatively recent phenomenon but at other times and places the ends have been racial or territorial security, support of a dynasty or regime and particular plans for saving souls. ... Those who begin the coercive elimination of dissent soon find themselves exterminating dissenters. Compulsory unification of opinion achieves only the unanimity of the graveyard.

....

[F]reedom to differ is not limited to things that do not matter much. That would be a mere shadow of freedom. The test of its substance is the right to differ as to things that touch the heart of the existing order. If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be

> orthodox in politics, nationalism, religion, or other matters of opinion, or force citizens to confess by word or act their faith therein.

319 U.S. 624, 641-42 (emphasis added).

Though purporting to assure "informed consent," these sections require both the profession of belief and the giving of false, misleading, one-sided and irrelevant information. While a doctor cannot complain of being required to give the objective information necessary to ensure informed consent, Planned Parenthood v. Danforth, 428 U.S. 52, 68 (1976), Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), cert den. 409 U.S. 1064 (1972), this ordinance converts the legitimate process of informed consent

into both a "straightjacket"* and a propaganda tool for the anti-abortion position. As such it violates not only the right to decide free of state interference, ** but also the first amendment right not to be coerced to speak or listen.

* Planned Parenthood v. Danforth, 428 U.S. n.8 at 68.

** See opinion of Sixth Circuit below, 651 F.2d 1198, 1207.

Despite the efforts of those opposed to abortion to create the appearance of a resolution of this deep underlying conflict over the value to be ascribed to prenatal life, it is clear that the conflict rages unabated.* It remains an irresoluble conflict between different conceptions of the meaning and sanctity of life, rooted in differing religious, moral, ethical teaching.

The effort to control abortion is a piece of a new "struggle to coerce uniformity" and dictate the bounds of permissible thought, belief, expression

* See, The Human Life Bill: Hearings on S.158 Before the Subcommittee on Separation of Powers of the Senate Committee on the Judiciary, 97th Cong., 1st Sess. (1981), The Human Life Bill - Appendix: Hearings on S.158 Before the Subcommitee on Separation of Powers of the Senate Committee on the Judiciary, 97th Cong., 1st Sess, and The Human Life Bill - S.158: Report, together with Additional and Minority Views to the Commitee on the Judciary made by its Subcommitee on Separation of Powers, 97th Cong., 1st Sess., hereinafter, Report of the East Subcommitee.

and action. The principle enunciated by this Court in Roe v. Wade--that the state may adopt no "theory of life" either to coerce or induce conformity--is the only one consistent with the first amendment and the preservation of the pluralistic society which it envisioned.

POINT III ORDINANCE NO. 160-1978, CHAPTER 1870, VIOLATES THE RELIGION CLAUSES OF THE FIRST AMENDMENT IN THAT IT INFRINGES THE FREE EXERCISE OF RELIGION AND TAKES SIDES IN A CONFLICT OVER RELIGIOUS PRINCIPLES.

The city ordinance at issue here is doubly violative of the first amendment. Not only does it require profession of a "theory of life" designed to induce women to forego abortion; it

also advances a "theory of life" which is inconsistent with religious and conscientious convictions themselves protected by the free exercise clause. Moreover, since the theory that life begins at conception (or shortly thereafter) is at its heart, religious in character, state-sponsorship thereof violates the establishment clause.

A. Chapter 1870 Violates The Right to Make and Effectuate a Conscientious Decision on Abortion Protected by the Free Exercise Clause.

Abortion ranks as a paramount concern in all major religious traditions. For those of the anti-abortion faiths, actual human life begins at or near conception and abortion is a grave sin, which destroys God's creation and is analogous to murder. Conversely, in the pro-choice faiths, the preservation of the health and

well-being of existing life, and consideration of the responsibilities of parenthood outweigh the interest in potential life and rank among the highest obligations of human beings towards one another and toward God.

The free exercise clause protects the right to believe or disbelieve. Torasco v. Watkins, 367 U.S. 488 (1961). It protects the right to practice one's beliefs, and to act in accordance with them, McDaniel v. Paty, 435 U.S. 618 (1978). It encompasses decisions about daily life which are "rooted in religious belief" rather than personal preference. Wisconsin v. Yoder, 406 U.S. 205, 215-16 (1972). And it shields the exercise of conscience: decisions that reflect "religious choice" even though not compelled by religious dogma, Thomas v. Review Bd., ____U.S.____, 101 S.Ct. 1425, 1430-31 (1981), and which are based on

"belief that occupies in the life of its possessor a place parallel to that filled by the orthdox belief in God." United States v. Seeger, 380 U.S. 163, 176 (1965).*

In this case, the lower courts heard testimony but held it unnecessary to make findings or conclusions on the free exercise claim. 479 F.Supp. 1172, 1203 (N.D. Ohio 1979); 651 F.2d 1198, 1201 (6th Cir. 1981). The free exercise claim was given extensive consideration, however, in McRae v. Califano, where the district court recognized that:

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* Though Seeger involved statutory interpretation of the conscientious objector exemption rather than a constitutional holding, the expansive interpretation was influenced by the concern for avoiding preferential treatment of the traditional believer as compared to the non-traditional one. United States v. Seeger, 380 U.S. at 176; see: Welsh v. United States, 398 U.S. 333 (1970) (Harlan, J., concurring). In Gillette v. United States, 401 U.S. 437 (1971), the selective objector claim, found to be outside the statutory exemption, nonetheless triggered scrutiny under both the free exercise and establishment clauses.

> A woman's conscientious decision, in consultation with her physician, to terminate her pregnancy because that is medically necessary to her health, is an exercise of the most fundamental of rights, nearly allied to her right to be, surely part of the liberty protected by the Fifth Amendment, doubly protected when the liberty is exercised in conformity with religious belief and training protected by the First Amendment ... The irreconcilable conflict of deeply and widely held views on this issue of individual conscience excluds any legislative intervention except that which protects each individual's freedom of concientious decision and conscientious nonparticipation.

McRae v. Califano, 491 F.Supp. 630,742, (E.D.N.Y. 1980), rev'd on other grounds sub nom. Harris v. McRae, 100 S.Ct. 2671 (1980).*

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* The Court did not review this aspect of McRae because the named plaintiffs lacked standing to raise this claim. Harris v. McRae, 100 S.Ct. at 2689-90. Here, there is no standing problem as plaintiff Dr. Bliss testified both that the informed consent statute was contrary to his beliefs and that the view expressed by ¶1870.06(B)(3) is a religious one. (Bliss, T.V., p. 128, 110, 111).

The free exercise clause protects against direct and indirect schemes to discourage religious exercise. A state invades the realm of freedom of religion if it purposefully, or even inadvertently, conditions benefits or exacts a toll that puts "substantial pressure on an adherent to modify his [her] behavior and to violate his [her] belief." Thomas v. Review Board, ____ U.S. ____, 101 S.Ct. at 1431-32; Sherbert v. Verner, 374 U.S. 398, 404-07 (1963). Thus, the protection afforded by the free exercise clause against even indirect and unintentional infringements of freedom of conscience is more sweeping than that afforded by the right to privacy. Compare Sherbert v. Verner, 374 U.S. 398 with Maher v. Roe, 432 U.S. 464, 474 (1974); Harris v. McRae, ___U.S.___, 100 S.Ct. 2671. At a minimum, regulations which impinge on a religious and

conscientious decision-making process protected by the right of privacy, likewise violate the free exercise clause.

To require a doctor to say and a woman to hear that "the unborn child is human life" clearly invades the shield afforded by the free exercise clause to the integrity of differing religious and conscientious beliefs. The statement is designed to advance the view that the fetus is a person and cause the woman to question her own beliefs and reconsider her decision to have an abortion.

The offense of Chapter 1870 to the free exercise of religion does not stop, however, with the required pronouncement of competing belief. The other constraints on the informed consent process -- the giving of irrelevant, false, misleading,

erroneous and distorted information as to risks and benefits, or the availability of adoption services -- are designed to induce a woman to renounce abortion or, at the least, to impugn her decision-making process. ¶1870.06(B).

Moreover, the mandatory waiting period, which both intrudes on the decisional process and burdens access to the means to effectuate the abortion decision, infringes the free exercise right to put one's religious choices into practice. Even if the moralistic preaching and parade of medical horribles required by ¶1870.06(B) and (C) were eliminated as unconstitutional, the mandatory waiting period remains to signify state disapproval of the decision to have an abortion. While counselors and doctors can and do suggest a waiting period to women who express ambivalence, most women seeking abortions have had

counseling and have, after considerable soul-searching, made up their mind before coming to the clinic.

Our constitution would not tolerate a state-imposed waiting period before undergoing adult baptism on the theory that the decision is a grave one; it cannot tolerate this stigmatizing, costly and medically risky delay here. Nor can the state make it more difficult or more dangerous -- as does the second trimester hospital requirement -- to effectuate religious or conscientious decisions.

These restrictions can be sustained only if the city can show that "it is the least restrictive means of achieving some compelling state interest," Wisconsin v. Yoder, 406 U.S. 205, (1972). "[T]he essence of all that has been said and written on the subject is that only those interests of

the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion." Ibid. at 216. See also McDaniel v. Paty, 435 U.S. at 628 (1978).

Here, there is no such interest. While the ordinance claims a purpose of protecting maternal health, this is belied by the indoctrination and scare tactics of the informed consent provisions as well as by the significant additional health dangers for women created by the waiting period and the second trimester hospital requirement. Nor can interest in potential life be asserted in defense of the ordinance, since such an interest is, by definition, not compelling until the third trimester. Roe v. Wade, 910 U.S. at 164. See also: Maher v. Roe, 432 U.S. at 472-76; McRae v. Harris, 101 S.Ct. at 2687. Before the third trimester, therefore, the state can

assert no interest sufficient to justify encroachment on religious freedom to choose abortion.

B. Chapter 1870 Discriminatorily Burdens Women for Whom Abortion is a Decision of Conscience and Doctors Who Assist Women in the Effectuation of Their Decisions in Violation of the Obligation of State Neutrality Commanded by the Free Exercise Clause.

If Akron had adopted a rule that all candidates for prenatal care must be thoroughly counseled about the particular dangers of carrying their pregnancies to term, given information about abortion services, and told to go home for at least 24 hours and reconsider whether childbirth is indeed the proper moral course
under the circumstances, the outcry would be deafening.

The example illustrates the discriminatory character of the Akron ordinance at issue. Those who, out of

religious or conscientious conviction, determine that abortion is proper, are subjected to a program of discouragement, deterrence and delay, while women who for similar reasons are compelled to or opt to bear a child suffer no such hindrance in the effectuation of their religious choice. Those who choose abortion are being sent home, not to advance their health or some independent, secular, and neutral purpose, but for the purpose of inducing them to consider and obey the contrary belief that "the unborn child is human life" -- a belief which is intrinsically religious.

The discrimination accomplished by Chapter 1870 is not at all inadvertent; it is explicit in the statutory scheme. Doctors who are opposed to abortion are protected against being required to participate in abortion under Chapter

1870 itself as well as under state law. ¶1870.14 Ohio Rev. Code Ann. ¶4731.91 (page 1977). By contrast to this respect for conscientious convictions of those opposed to abortion, the Akron ordinance requires pro-choice doctors to participate in an informed consent process which violates their conscientious beliefs as well as their ethical and professional commitments.

This case thus involves the "constitutionally imposed 'governmental obligation of neutrality' originating in the establishment and free exercise clauses of the First Amendment." Maher, 432 U.S. at 474, n.8, quoting Sherbert v. Verner, 374 U.S. at 409. Neutrality as between differing religious and non-religious views and practices is a core principle of the first amendment. It has long been settled that "a state can[not], consistent with the First

Amendment, pass laws which ... prefer one religion over another." See Everson v. Board of Education, 330 U.S. 1, 15 (1947).

The requirement of neutrality is strict where the free exercise of religion is at issue. See Walz v. Tax Commission, 397 U.S. 664 (1970). The free exercise clause "prohibits misuse of secular governmental programs 'to impede the observance of one or more religions or to discriminate invidiously between religions ... even though the burden may be characterized as being only indirect.' Braunfeld v. Brown, 366 U.S. 599 (1961) at 607." Gillette v. United States, 401 U.S. at 462. Thus Sherbert not only held that the Sunday work requirement was an impermissible burden on free exercise of a sabbatarian;

it also held that the "unconstitutionality of the disqualification ... is thus compounded by ... religious discrimination" in that, by contrast to the treatment of the sabbatarian, the emergency labor laws exempted those who were "conscientiously opposed to Sunday work." 374 U.S. at 406.

Equal treatment of both the woman whose conscience dictates abortion rather than childbirth and the doctor who assists her requires that this one-sided ordinance be invalidated. See also: United States v. Seeger, 380 U.S. 163 (1965); Welsh v. United States, 398 U.S. 333 (1970). The lack of compelling let alone colorable interest for this ordinance is thus highlighted by the religious discrimination it effects.

Far from advancing maternal health or an objectively informed decision, the goal of the ordinance was to convert or

at least shame women whose conscience dictated abortion, contrary to Akron's moral and religious position that abortion is the taking of human life.

This Court has repeatedly held in first amendment cases that mere disagreement with the content of belief or protected action does not suffice to justify infringement. See e.g., Fowler v. Rhode Island, 345 U.S. 67, 69-70 (1953); Niemotko v. Maryland, 340 U.S. 268, 272-73 (1951); Murdock v. Pennsylvania, 319 U.S. 105, 116 (1943); Ballard v. United States, 322 U.S. 78 (1944). Only where the free exercise of religion would pose a "substantial threat to public safety, peace and order," Sherbert v. Verner, 374 U.S. at 403, can the state counterpose its moral view against that of the believer. See e.g., Prince v. Massachusetts, 321 U.S. 158

(1944); Jacobson v. Massachusetts, 197 U.S. 11 (1905).

If this were not so, then the protection afforded by the free exercise clause would be swallowed up by the moral disapproval that particular beliefs and practices often inspire. Since plaintiffs here seek to obtain a perfectly legal service, the moral position adopted by the state cannot itself satisfy the compelling interest test, let alone qualify as legitimate in this context.

As Judge Dooling concluded in McRae: "The irreconcilable conflict of deeply and widely held views on this issue of individual conscience excludes any legislative intervention except that which protects each individual's freedom of conscientious decision and conscientious nonparticipation." Invalidation of ¶1870 is thus required

to preserve the free exercise of religion and the state's obligation of neutrality in this regard.

C. Chapter 1870 Constitutes State Sponsorship of One Religious Belief in Violation of the Establishment Clause of the First Amendment.

As this Court recognized in Sherbert, state neutrality on matters of conflicting religious belief is required by the establishment clause was well. 374 U.S. at 409. Not only does this ordinance disfavor one segment of religious believers in this society; it also favors one segment of religious belief about the creation of human life and thereby violates the principle that the state may not sponsor or place its authority on the side of a particular religious position. Engel v. Vitale, 370 U.S. 421, 429-30; School District of Abington v. Schempp, 374 U.S. 203

261-63 (1963); Walz v. Tax Commission, 379 U.S. 664 (1970) at 668. As the Court held in Everson v. Board of Education:

> The 'establishment of religion' clause of the First Amendment means at least this. Neither a state nor the Federal government ... can pass laws which aid one religion, and all religions, or prefer one religion over another. Neither can force nor influence a person ... to profess a belief or disbelief in any religion. No person can be punished for entertaining or professing religious beliefs or disbeliefs. ...

330 U.S. 1, 15 (1947).

The City of Akron cannot purge this ordinance of its religious character by conceding the impermissibility of ¶¶1870.06(B)(3)(4) and (5). It is clear, as stated in the preamble,* that the entire ordinance is premised upon and seeks to advance the

* See n* at 17 , supra.

belief that human life begins at conception. This view does not simply coincide with the dogmas of certain religious groups. Cf. Harris v. McRae, ___U.S.___, 100 S.Ct. 2671; it is a belief which is, at the core, inescapably in the "realm of religion -- where knowledge leaves off and faith begins."* As Justice Frankfurter defined it:

> The establishment clause withdrew from the sphere of legitimate concern and competence a specific but comprehensive area of human conduct: man's belief or disbelief in the verity of some transcendental idea and man's expression in action of that belief or disbelief. Congress may not make these matters, as such, the subject of legislation ... nor ... by any device, support belief or the expression of belief, for its own sake, whether from conviction of the truth of that belief, or from conviction that by propagation of that belief the

* Wolman v. Walter, 433 U.S. 229, 264 (1977) (Stevens, J., concurring and dissenting, quouting C. Darrow, Tr. of Oral Argument 7 Scopes v. State), 154 Tenn. 105, 289 S.W. 363 (1927).

> civil welfare of the state is served, or because a majority of its citizens, holding that belief, are offended when all do not hold it.

McGowan v. Maryland, 366 U.S. 420 (1961) at 465-66 (concurring). And. more recently in United States v. Seeger, this Court recognized contemporary definitions of religion which are particularly applicable to the matter of abortion.*

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* For example, a Vatican II draft declaration of the Church's relations with non-Christians states:

> Men expect from the various religions answers to the riddles of human condition. What is man? What is the meaning and purpose of our lives? What is the moral good and what is sin? What are death, judgment and retribution after death?

380 U.S. at 182. And Dr. Paul Tillich, who writes of God as the source of meaning within meaninglessness, explains:

> And if that word [God] has not much meaning for you, translate it, and speak of the depths of your life, of the source of your being, of your ultimate concern, of what you take seriously without any reservation. Perhaps, in order to do so, you must forget everything traditional that you have learned about God. ... Tillich, The Shaking of the Foundations 57 (1948).

380 U.S. at 187.

Amici view the notion that "the unborn child is human life" as one which is rooted in theological belief.* By enacting restrictions on abortion which are premised on and seek to propagate this belief, the Akron City Council has impermissibly taken sides

* Biology, invoked by the preamble and by ¶1870.06(B)(4), obviously cannot impart to the conceptus the value of human life. Despite popular rhetoric to the contrary, this is widely recognized. See, e.g., the 1974 "Declaration on Abortion" issued by the Sacred Congregation for the Doctrine of Faith of the Roman Catholic Church which holds: "It is not up to biological sciences to make a definite judgment on questions which are properly philosophical and moral, such as the moment when a human person is constituted. From a moral point of view this is certain:...'The one who will be a man is already one.'" p.6. And the East Senate Subcommittee on Separation of Powers that held hearings on S.158, which sought to base a declaration of personhood on biological evidence alone, was finally forced to concede: "Through those hearings we have also come to recognize that the finamental question concerning the life and humanity of the unborn is two fold:...Science cannot tell us what value to give to each human life. This second question can be answered only in light of the ethical and legal values held by our citizens and experienced by the framers of the Constitution. Report of East Subcommitte, at p. 3.

in a religious controversy. Doctors are made to profess belief which they view as religious and with which they differ; women are forced to listen and wait. The fact that no woman is required to forego abortion is irrelevant. "The absence of any element of coercion...is irrelevant to questions arising under the Establishment Clause." Committee for Public Education v. Nyquist, 413 U.S. 756, 786 (1973); School District of Abington v. Schempp, 374 U.S. at 224, n. 9; Engel v. Vitale, 370 U.St. at 430-31; People ex rel. McCollum v. Board of Education, 333 U.S. 203, 228 (1948). The desired effect of this ordinance is to induce women to "meditate upon" the position which opposes abortion and "perhaps to venerate and obey [it]." Stone v. Graham, ____U.S.____ , 101 S.Ct. 192, 194.

Moreover, the fact that this local authority has taken a position that deprecates a moral decision sacred to dissenting faiths threatens the dangers of intolerance, oppression and sectarian strife that the establishment clause was designed to avert. Everson v. Board of Education, 330 U.S. 1, 15-16, 53-55 (Rutledge, J. dissenting). Where as here, an issue is perceived as religious generally, and particularly by dissenting faiths, state sponsorship sacrifices the neutrality necessary to the preservation of religious harmony and the public peace. People ex rel. McCollum, 333 U.S. at 28 n. 19. James Madison remonstrated that against any state support for religious belief, even purportedly even-handed support:

> Because, it will destroy that moderation and harmony which the borebearance of our laws to intermeddle with Religion, has produced among its several sects. Torrents of blood have

> been spilt in the old world, by vain attempt of the secular arm to extinguish Religious discord, by proscribing all difference in Religious opionions...If...we begin to contract the bonds of Religious freedom, we know no name that will too severely reproach our folly. At least let warning be taken of the first fruit of the threatened inovation"

"Memorial and Remonstrance," reprinted in Everson v. Board of Education, 330 U.S. at 69 (Appendix to Rutledge, J. dissenting).

Madison's warning sounds far too contemporary. The effort reflected in this ordinance and the other laws before this Court to advance the belief that life begins at conception and stop or discourage abortion is part of a program pressed by a new and dangerous religious movement to undo the separation of church and state guaranteed by the first amendment. This Court is the ultimate refuge for the freedom of conscience that the no-establishment principle preserves.

CONCLUSION

The liberty of conscience, guaranteed by the first amendment's prohibition on state sponsorship or imposition of any belief, let alone religious belief -- these are corner-stones of our pluralistic democratic society. The battle raging over abortion is not a battle between good and evil, as some may see it, but is rather a battle between differing conceptions of the good. Each conception is grounded in profound religious, moral and ethical principles, and each is equally incomprehensible and offensive to those who believe otherwise.

This Court's decision in Roe v. Wade charts the only course acceptable under our constitution--refusing to government the power to adopt a "theory of life," and guaranteeing to women a

sphere of untrammeled privacy for the exercise and effectuation of their own, differing conscientious convictions. Any departure from the principles of Roe v. Wade threatens not only the right to abortion, but the foundation of individual freedom under the constitution. As James Madison said: "[I]t is proper to take alarm at the first experiment on our liberties..." "Memorial and Remonstrance" in Everson v. Board of Education, 330 U.S. at 65-66 (Appendix to Opinion of Rutledge, J., dissenting).

WHEREFORE, the Ordinance should be invalidated.

Respectfully submitted,

RHONDA COPELON
c/o Center for Constitutional Rights
853 Broadway
New York, New York 10003
(212) 674-3303

Counsel would like to thank law student Jenny Wriggins, from Harvard Law School, for her help in the preparation of this brief.

APPENDIX A

RELIGIOUS COALITION FOR ABORTION RIGHTS

(1979)

Statement of Purpose: The Religious Coalition for Abortion Rights is an organization of national religious bodies which, on the basis of faith and moral conviction and in the light of constitutional guarantees of privacy and religious freedom, seeks to encourage and coordinate support for safeguarding the legal option of abortion; for ensuring the right of individuals to make decisions concerning abortion in accordance with their consciences and responsible medical practice; and for opposing efforts to deny these rights through constitutional amendment, or federal and state legislation.

Rationale: Many religious organizations

representing diverse denominations have adopted the position that decisions concerning abortion would be made according to individual conscience, consistent with responsible medical practice, free from the threat of criminal penalty...

However, a vocal minority would deny the option of legal abortion to all. Their personal belief that human life exists from the moment of conception has prompted their efforts to nullify the Supreme Court decision through a Constitutional amendment which would restrict access to abortion. One theological view would thus become law, binding on Americans of all faiths.

It is vital to increase public awareness of this danger. Enactment of such legislation would violate the religious freedom of every citizen by circumventing the First Amendment

guarantee of church-state separation.

APPENDIX B

The following are excerpts from statements about abortion by national religious organizations:

AMERICAN BAPTIST CHURCHES, U.S.A. (Annual Meeting, 1968)

Because Christ calls us to affirm the freedom of persons and sanctity of life, we recognize that abortion would be a matter of personal decision.

AMERICAN ETHICAL UNION (1965, reaffirmed 1979)

Abridgement of individual civil and human liberties as guaranteed by the United States Constitution is a danger to all. Among those liberties that must continue free of threat is the right of every woman to self-determination insofar

as continued pregnancy is concerned.

AMERICAN ETHICAL UNION,
NATIONAL WOMEN'S CONFERENCE
(1976, reaffirmed 1979)

We believe in the right of each individual to exercise his or her conscience; every woman has a civil and human right to determine whether or not to continue her pregnancy. We support the decision of the United States Supreme Court of January 22, 1973 regarding abortion.

We believe that no religious belief should be legislated into the legal structure of our country; the state must be neutral in all matters related to religious concepts.

AMERICAN FRIENDS SERVICE COMMITTEE
(1970)

On religious, moral, and humanitarian grounds, therefore, we arrived at the

view that it is far better to end an unwanted pregnancy than to encourage the evils resulting from forced pregnancy and childbirth. At the center of our position is a profound respect and reverence for human life, not only that of the potential human being who should never have been conceived, but that of the parent, the other children and the community of man.

Believing that abortion should be subject to the same regulations and safeguards as those governing other medical and surgical procedures, we urge the repeal of all laws limiting either the circumstances under which a woman may have an abortion or the physician's freedom to use his best professional judgment in performing it.

AMERICAN HUMANIST ASSOCIATION
(Annual Conference, 1977)

We affirm the moral right of women to become pregnant by choice and to become mothers by choice. We affirm the moral right of women to freely choose a termination of unwanted pregnancies. We oppose actions by individuals, organizations and governmental bodies that attempt to restrict and limit the women's moral right and obligation of responsible parenthood.

AMERICAN JEWISH CONGRESS and
WOMEN'S DIVISION, AMERICAN
JEWISH CONGRESS
(Biennial Convention, 1978)

The American Jewish Congress respects the religious and conscientious scruples of those who reject the practice of abortion. However, to the extent that they would embody those scruples in law binding on all, we oppose them.

We reaffirm our position that all laws

prohibiting or restricting abortion should be repealed. We believe that it is the right of a woman to choose whether to bear a child and that restrictive or prohibitive abortion laws violate a woman's right of privacy and liberty in matters pertaining to marriage, family and sex.

BAPTIST JOINT COMMITTEE ON PUBLIC AFFAIRS
(1973)

It was voted that the Baptist Joint Committee on Public Affairs go on record as opposed to the Buckley-Hatfield amendment and any like or similar constitutional amendments, and that the staff be authorized to take all available action to oppose them.

B'NAI B'RITH WOMEN
(Biennial Convention, 1976,
reaffirmed 1978)

We wholeheartedly support the concepts

of individual freedom of conscience and choice in the matter of abortion. Any constitutional amendment prohibiting abortion would deny to the population at large their basic rights to follow their own teachings and attitudes on this subject which would threaten First Amendment rights. Additionally, legislation designed to ban federal funding for health facilities for abortions is discriminatory, since it would affect disadvantaged women, who have no access to expensive private institutions.

CATHOLICS FOR A FREE CHOICE
(1975)

We affirm the religious liberty of Catholic women and men and those of other religions to make decisions regarding their own fertility free from church or

governmental interventions in accordance with their own individual conscience.

CENTRAL CONFERENCE OF AMERICAN RABBIS
(1975)

We believe that in any decision whether or not to terminate a pregnancy, the individual family or woman must weigh the tradition as they struggle to formulate their own religious and moral criteria ftor each their own personal decision... We believe that the proper focus for formulating these religious and moral criteria and for making this decision must be the individual family or woman and not the state or other external agency.

As we would not impose the historic position of Jewish teaching upon individuals nor legislate as normative for society at large, so we would not wish the position of any other group

imposed on the Jewish community or the general population.

We affirm the legal right of a family or a woman to determine on the basis of their or her own religious and moral values whether or not to terminate a particular pregnancy. We reject all constitutional amendments which would abride or circumscribe this right.

CHRISTIAN CHURCH (DISCIPLES OF CHRIST)
(General Assembly, 1975)

Therefore be it resolved, that the General Assembly of the Christian Church (Disciples of Christ)

1. Affirm the principle of individual liberty, freedom of individual conscience, and sacredness of life for all persons.

2. Respect differences in religious biliefs concerning abortion and oppose, in accord with the principle of religious

liberty, any attempt to legislate a specific religious opinion or belief concerning abortion upon all Americans.

EPISCOPAL CHURCH
(General Convention, 1976)

Resolved: That the Episcopal Church express its unequivocal opposition to any legislation on the part of the national or state governments which would abridge or deny the right of individuals to reach informed decisions in this matter and to act upon them.

FEDERATION OF RECONSTRUCTIONIST CONGREGATIONS AND HAVUROT
(1981)

Although the Jewish tradition regards children as a blessing, a gift of life itself, the tradition permits the abortion of an unborn child in order to safeguard the life and the physical and mental health of the mother. The rabbis

did not take a consistent stand on the question of whether a fetus resembles 'a person.' They did not think it possible to arrive at a final theoretical answer to the question of abortion, for that would mean nothing less than to be able to define convincingly what it means to be human.

We recognize that abortion is a tragic choice. Any prospective parent must make an agonizing decision between competing claims--the fetus, health, the need to support oneself and one's family, the need for time for a marriage to stabilize, responsiblity for other children and the like. Some of us consider abortion to be immoral except under the most extraordinary circumstances. Yet we all empathize with the anguish of those who must make the decision to abort or not to abort.

LUTHERAN CHURCH IN AMERICA
(Biennial Convention, 1970,
reaffirmed 1978)

Since the fetus is the organic beginning of human life, the termination of its development is always a serious matter. Nevertheless, a qualitative distinction must be made between its claims and the rights of a responsible person made in God's image who is in living relationships with God and other human beings. This understanding of responsible personhood is congruent with the historical Lutheran teaching and practice whereby only living persons are baptized.

On the basis of the evangelical ethic, a woman or couple may decide responsibly to seek an abortion. Earnest consideration should be given to the life and total health of the mother, her responsibilities to others in her family, the stage of development of the fetus,

the economic and psychological stability of the home, the laws of the land, and the consequences for society as a whole.

MORAVIAN CHURCH IN AMERICA,
NORTHERN PROVINCE
(1974)

Whereas the Moravian Church believes in the sacredness of life and in the quality of life, and whereas we believe that abortion should not be used as a method of birth control nor a means of controlling population, and whereas Christian faith calls us to affirm the freedom of persons as well as the sanctity of life, be it resolved that abortion should be a matter of responsible personal decision, with continuing counseling provided if desired.

NATIONAL COALITION OF AMERICAN NUNS
(1982)

For thirteen years, the NCAN has debated the abortion issue.

While we continue to oppose abortion, in principle and in practice, we are likewise convinced that the responsibility for decisions in this regard resides primarily with those who are directly and personally involved.

NATIONAL COUNCIL OF JEWISH WOMEN
(National Convention, 1969,
reaffirmed, 1979)

The members of the National Council of Jewish Women reaffirm the firm commitment of "work to protect every woman's individual right to choose abortion and to eliminate any obstacles that would limit her reproductive freedom."

NATIONAL FEDERATION OF TEMPLE SISTERHOODS
(Biennial Assembly, 1975)

The National Federation of Temple Sisterhoods affirms our strong support for the right of a woman to obtain a legal abortion, under conditions now outlined in the 1973 decision of the United States Supreme Court. The Court's position established that during the first two trimesters, the private and personal decision of whether or not to continue to term an unwanted pregnancy should remain a matter of choice for the woman; she alone can exercise her ethical and religious judgment in this decision.

PRESBYTERIAN CHURCH IN THE U.S.
(General Assembly, 1970,
reaffirmed 1981)

The willful termination of pregnancy by medical means on the considered decision of a pregnant woman may on occasion be

morally justifiable. Possible justifying circumstances would include medical indications of physical or mental deformity, conception as a result of rape or incest, conditions under which the physical or mental health of either mother or child would be gravely threatened, or the socio-economic condition of the family...

Because of the great diversity in the scientific and theological disciplines as to when life begins, no single religious position should claim universal opinion and become the law. This seems to breach the basis for church and state separation. While laws may legislate behavior, they cannot legislate morality.

REFORMED CHURCH IN AMERICA
(General Synod, 1975)

To use, or not to use, legal abortion should be a carefully considered decision

of all the persons involved, made prayerfully in the love of Jesus Christ.

Christians and the Christian community should play a supportive role for persons making a decision about or utilizing abortion.

REORGANIZED CHURCH OF JESUS CHRIST OF LATTER DAY SAINTS
(1974, reaffirmed 1980)

We affirm that parenthood is partnership with God in the creative processes of the universe.

We affirm the necessity for parents to make responsible decisions regarding the conception and nurture of their children.

We affirm a profound regard for the personhood of the woman in her emotional, mental and physical health; we also affirm a profound regard and concern for the potential of the unborn fetus.

We affirm the inadequacy of simplistic answers that regard all abortions as

murder or, on the other hand, regard abortion only as a medical procedure without moral significance.

We affirm the right of the woman to make her own decision regarding the continuation or termination of problem pregnancies.

UNION OF AMERICAN HEBREW CONGREGATIONS
(Biennial Convention, 1975)

The UAHC reaffirms its strong support for the right of a woman to obtain a legal abortion on the constitutional grounds enunciated by the Supreme Court in its 1973 decision... This rule is a sound and enlightened position on this sensitive and difficult issue, and we express our confidence in the ability of the woman to exercise her ethical and religious judgment in making her decision.

The Supreme Court held that the question of when life begins is a matter of religious belief and not medical or legal fact. While recognizing the right of religious groups whose beliefs differ from ours to follow the dictates of their faith in this matter, we vigorously oppose the attempts to legislate the particular beliefs of those groups into the law which governs us all. This is a clear violation of the First Amendment. Furthermore, it may undermine the development of interfaith activities. Mutual respect and tolerance must remain the foundation of interreligious relations.

UNITARIAN UNIVERSALIST ASSOCIATION
(General Assembly, 1977)

WHEREAS, attempts are now being made to deny Medicaid funds for abortion and to enact Constitutional amendments that

would limit abortions to life-endangering situations and thus remove this decision from the individual and her physician; and

WHEREAS, such legislation is an infringement of the principle of the separation of church and state as it tries to enact a position of private morality into public law; and

WHEREAS, we affirm the right of each woman to make the decisions concerning her own body and future and we stress the responsibilities and long-term commitment involved in the choice of parenthood,

THEREFORE, BE IT RESOLVED: that the 1977 General Assembly of the Unitarian Universalist Association goes on record as opposing the calling of a national constitutional convention for the purpose of amending the Constitution to prohibit abortion.

UNITARIAN UNIVERSALIST WOMEN'S FEDERATION
((Biennial Convention, 1975)

The Unitarian Universalist Women's Federation reaffirm[s] the right of any woman of any age or marital or economic status to have an abortion at her own request upon consultation with her physician...

UNITED CHURCH OF CHRIST
(General Synod, 1981)

The question of when life (personhood) begins is basic to the abortion debate. It is primarily a theological question, on which denominations or religious groups must be permitted to establish and follow their own teachings;

Every woman must have the freedom of choice to follow her personal and religious and moral convictions concerning the completion or termination of her pregnancy. The church as a caring community should provide counseling

services and support for those women with both wanted and unwanted pregnancies to assist them in exploring all alternatives;

UNITED METHODIST CHURCH
(General Conference, 1976, 1980)

When an unacceptable pregnancy occurs, a family, and most of all the pregnant woman, is confronted with the need to make a difficult decision. We believe that continuance of a pregnancy which endangers the life or health of the mother, or poses other serious problems concerning the life, health, or mental capability of the child to be, is not a moral necessity. In such a case, we believe the path of mature Christian judgment may indicate the advisability of abortion. We support the legal right to abortion as established by the 1973 Supreme Court decisions. We encourage

women in counsel with husbands, dotors, and pastors to make their own responsible decisions concerning the personal or moral questions surrounding the issue of abortion. (Resolution on Responsible Parenthood, 1976.)

Our belief in the sanctity of unborn human life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of the life and well-being of the mother, for whom devastating damage may result from an unacceptable pregnancy. In continuity with past Christian teaching, we recognize tragic conflicts of life with life that may justify abortion. (Social Principles, 1976, reaffirmed 1980.)

WOMEN'S DIVISION
GENERAL BOARD OF GLOBAL MINISTRIES
UNITED METHODIST CHURCH
(1975, reaffirmed 1979, 1980)

We believe deeply that all should be free to express and practice their own moral judgment on the matter of abortion. We also believe that on this matter, where there is no ethical or theological consensus, and where widely differing views are held by substantial sections of the religious community, the Constitution should not be used to enforce one particular religious belief on those who believe otherwise.

UNITED PRESBYTERIAN CHURCH IN THE U.S.A.
(General Assembly, 1972, reaffirmed 1978)

Whereas, God has given persons the responsibility of caring for creation as well as the ability to share in it, and has shown his concern for the quality and value of human life; and

Whereas, sometimes when the natural ability to create life and the moral and spiritual ability to sustain it are not in harmony, the decisions to be made must be understood as moral and ethical ones and not simply legal;

Therefore, in support of the concern for the value of human life and human wholeness...the 184th General Assembly:

b. Declares that women should have full freedom of personal choice concerning the completion or termination of their pregnancies and that artificial or induced termination of pregnancy, therefore, should not be restricted by law, except that it be performed under the direction and control of a properly licensed physician.

UNITED SYNAGOGUE OF AMERICA
(Biennial Convention, 1975)

"In all cases 'the mother's life takes precedence over that of the foetus' up to the minute of its birth. This is to us an unequivocal principle. A threat to her basic health is moreover equated with a threat to her life. To go a step further, a classical responsum places danger to one's pshychological health, when well established, on an equal footing with a threat to one's physical health." (1967)

[A]bortions, "though serious even in the early stages of conception, are not to be equated with murder, hardly more than is the decision not to become pregnant."

The United Synagogue affirms once again its position that "abortions involve very serious psychological, religious, moral

problems, but the welfare of the mother must always be our primary concern."

WOMEN OF THE EPISCOPAL CHURCH
(Triennial Meeting, 1973)

Whereas the Church stands for the exercise of freedom of conscience by all and is required to fight for the right of everyone to exercise that conscience, therefore, be it resolved that the decision of the U.S. Supreme Court allowing women to exercise their conscience in the matter of abortion be endorsed by the Church.

WOMEN'S LEAGUE FOR CONSERVATIVE JUDAISM
(Biennial Convention, 1974)

National Women's League believes that freedom of choice as to birth control is inherent in the civil rights of women.

YOUNG WOMEN'S CHRISTIAN
ASSOCIATION, U.S.A.
(1979)

As an organization rooted in the Christian faith, the YWCA is deeply conscious of the difficult personal and ethical choices raised by the issue of abortion.

The position of the YWCA is not "pro-abortion." It is a position supporting a woman's right to make an individual decision based upon her own religious and ethical beliefs and her physician's guidance. The answer to the question, "When does personhood begin?" must remain in the ethical and religious realm.

Since there is a wide variation of opinion among religious groups and individuals in our pluralistic society as to when personhood begins and what an ethical decision on abortion may be in different circumstances, the YWCA holds that no <u>one</u> religious belief should be

mandated by law. Our government is expressly commanded to make no law establishing any one religion or prohibiting free expression of religion.

APPENDIX C

A CALL TO CONCERN
(signed by 220 American religious ethicists in 1978)

The increasing urgency of the issue of abortion rights requires us as teachers and writers of religious ethics to speak out.

Abortion is a serious and sometimes tragic procedure for dealing with fetal life. It raises important ethical issues and cannot be blandly legitimized by the mere whim of an individual. Nevertheless, it belongs in that large realm of often tragic actions where circumstances can render it a less

destructive procedure than the rigid prolongation of pregnancy.

We support the Supreme Court decisions of 1973 which had the effect of removing abortion from the criminal law codes. The Court did not appeal to religion or ethics in arriving at its judgment, but we believe the decision to have been in accord with sound ethical judgment. Taking note of the fact that theologians, as well as other experts, disagree on the fundamental moral question of when life begins, the Court decided that the law ought not to compel the conscience of those who believe abortion to be in harmony with their moral convictions.

In the last four years, however, those decisions have been subjected to a relentless attack from those who take the absolutist position that it is always wrong to terminate a pregnancy at any time after the moment of conception.

Those who take this absolutist position have not hesitated to equate abortion at any stage of pregnancy with murder or manslaughter. From such an extreme viewpoint, all legal means are considered justified if they limit abortion, no matter what the human consequences for poor women and others--as in the recent efforts to deny Mediciad funds and to prohibit use of public hospitals for abortion services.

We feel compelled to affirm an alternative position as a matter of conscience and professional responsibility.

1. <u>The most compelling argument against the inflexibility of the absolutist position is its cost in human misery.</u> The absolutist position does not concern itself about the quality of the entire life cycle, the health and well-being of the mother and family, the question of

emotional and economic resources, the cases of extreme deformity. Its total preoccupation with the status of the unborn renders it blind to the well-being and freedom of choice of persons in community.

2. "Pro-life" must not be limited to concern for the unborn; it must include a concern for the quality of life as a whole. The affirmation of life in Judeao-Christian ethics requires a commitment to make life healthy and whole from beginning to end. Considering the best medical advice, the best moral insight, and a concern for the total quality of the whole life cycle for the born and the unborn, we believe that abortion may in some instances be the most loving act possible.

3. We believe it is wrong to deny Medicaid assistance to poor women seeking abortions. This denial makes it

difficult for those who need it most to exercise a legal right, and it implies public censure of a form of medical service which in fact has the moral support of major religious groups.

4. We are saddened by the heavy institutional involvement of the bishops of the Roman Catholic Church in a campaign to enact religiously-based anti-abortion commitments into law, and we view this as a serious threat to religious liberty and freedom of conscience. We acknowledge the legal right of all individuals and groups, both religious and secular, to seek laws that reflect their religious and ethical beliefs. But the institutional mobilization of Roman Catholic dioceses, including massive financial contributions by those dioceses to the National Committee for a Human Life Amendment, is inappropriate on this issue. If

successful, it would violate the deeply held religious convictions of individual members and official bodies of many other religious groups about when human personhood begins, the relative rights of a woman and a fetus, and responsible family life. This is particularly a problem when there is no clear majority opinion on these fundamental issues nor an adequate social base of consensus for legitimate and enforceable legislation.

5. We call upon the leaders of religious groups supporting abortion rights to speak out more clearly and publicly in response to the dangerously increasing influence of the absolutist position. There may be some ecumenical risks in such candor, but those risks have already been assumed by those who have pressed the absolutist position on religious grounds. In the long run, the true test of ecumenical authenticity is

the ability to sustain dialogue and friendship in spite of very sharp disagreements on matters of substance.

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No. 81-746

In the Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC.

On Writ of Certiori to the United States Court of Appeals for the Sixth Circuit

BRIEF OF AMICI CURIAE UNITED FAMILIES FOUNDATION AND WOMEN EXPLOITED IN SUPPORT OF PETITIONER, THE CITY OF AKRON

LYNN D. WARDLE
518 J.R.C.B.
Brigham Young University
Provo, Utah 84062
801/378-2617

Counsel for the Amici

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Brigham Young University
Provo, Utah 84062
801/378-2617

Counsel for the Amici

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES v

INTERESTS OF THE AMICI 1

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. BEFORE SUBJECTING A PROPERLY ENACTED ABORTION REGULATION TO STRICT JUDICIAL SCRUTINY, A COURT MUST DETERMINE THAT IT SIGNIFICANTLY BURDENS OR SUBSTANTIALLY INFRINGES THE FUNDAMENTAL RIGHT OF ABORTION PRIVACY. 3

A. *A Determination That A Regulation Affecting Abortion Burdens Or Impinges Upon The Fundamental Right Of Abortion Privacy Must Be Made Before It Is Subjected To The Exacting Review Of Strict Judicial Scrutiny.* . 3

B. *An Abortion Regulation Is Subject To Strict Judicial Scrutiny Only After There Has Been A Clear Showing That It Seriously Restrains Or Obstructs A Woman's Constitutional Right To Choose To Terminate Her Pregnancy.* 7

II. THE SOCIO-LEGAL CONTEXT IN WHICH THIS CASE ARISES IS SIGNIFICANT. 10

A. *This Country Is Experiencing An Abortion Epidemic.* 10

B. *The Right of Abortion Privacy Is A Unique Right.* 13

C. *The Court Needs To Clarify General Principles For The Benefit Of The Lower Courts.* ... 13

PAGE

III. THE CONSTITUTION DOES NOT PROHIBIT LOCAL AUTHORITIES FROM TREATING EARLY ADOLESCENTS DIFFERNT FROM OLDER ADOLESCENTS BY REQUIRING THAT GIRLS ONLY FOURTEEN YEARS OLD OR YOUNGER OBTAIN PARENTAL OR JUDICIAL CONSENT FOR AN ABORTION. 14

A. *Regulations Restricting the Constitutional Rights of Minors Are Not Subject to Strict Judicial Scrutiny.* 14

B. *The Right of Abortion Privacy Does Not Extend to Immature Minors.* 15

C. *There Are Profound Differences Between The Maturity of Girls Fourteen Years Old or Younger, and Girls Sixteen or Seventeen Years Old.* 16

D. *Requiring Parental or Judicial Concent Before An Abortion is Performed on a Girl Fourteen or Younger Clearly Promotes Significant State Interests.* 17

IV. THE AKRON INFORMED CONSENT AND WAITING PERIOD REQUIREMENTS DIRECTLY PROMOTE COMPELLING GOVERNMENTAL INTERESTS CONCERNING THE WELFARE OF PREGNANT WOMEN. 22

A. *Abortion Entails Serious Risks For A Woman.* 23

B. *Anxiety About Abortion is Reduced if All Material Information Regarding Her Condition, The Alternatives, Consequences, And Risks Have Been Disclosed To The Woman.* . 24

C. *Failure To Make Complete Disclosure Heightens The Risk of Negative Postabortion Psychological Sequelae.* 25

PAGE

D. *Abortion Counselors And Clinics Are Caught in a Conflict of Interests That Inhibits Their Voluntarily Making Full Disclosure.* 26

E. *Requiring Disclosure of The Facts Of Fetal Development By A Physician And a Mandatory Cooling Off Period Are Essential To Protect A Woman's Right To Make An Informed Decision.* 27

V. CONCLUSION 29

CERTIFICATE OF SERVICE 30

TABLE OF AUTHORITIES
CASES

PAGE

Akron Center of Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, (6th Cir. 1981). 7, 17 27, 28

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PAGE

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H.L. v. Matheson, 450 U.S. 398 (1981) 6, 15, 23

Kramer v. Union Free School District, 395 U.S. 621 (1969). 4, 8

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STATUTES:

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PAGE

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INTERESTS OF THE AMICI

United Families Foundation (UFF) is a non-partisan, non-profit research and education foundation associated with United Families of America, a nationwide organization established in 1977 with members in all 50 states and the District of Columbia. UFF was organized in part, to "educate the general public so that all will appreciate more fully the value of maintaining the family unit as the bedrock and strength of this nation, and [to] defend [the family] from all assaults that tend to fragment or weaken [it]."

As parents of young adolescents, many members of UFF are directly interested in seeing that laws preserving their right to protect their children against individuals and businesses that would exploit troubled teenagers are upheld. They also are directly interested in seeing that laws protecting a pregnant woman's right to full disclosure are upheld.

Women Exploited is an association of women who have been through the experience of abortion and who are dedicated to "raising the consciousness of their communities regarding the emotional and physical sequelae of abortion." Twenty-two chapters of Women Exploited have been established nationwide since 1975.

Women Exploited has been organied by and for women who have been exploited by the callous, profit-oriented practices of abortion industry workers whose financial interests in and philosophical zeal for abortion override their concern for the individual plights of the women who come to them—often in great distress—for counsel and assistance with a profound personal crisis. Member of Women Exploited are deeply and personally interested in seeing that vulnerable women—their pregnant sisters throughout America—are given all of the facts about abortion, alternatives and consequences, and are given time to consider those facts before being rushed by self-satisfied abortion counselors into the operating room to submit to an abortion.

The written consent of all the parties to the filing of this brief has been obtained and has been filed with the Clerk of the Court under separate cover.

SUMMARY OF ARGUMENT

This case comes before the Court in a unique and sensitive context. Since this Court constitutionalized the right to abortion in *Roe v. Wade*, U.S. 113 (1973), abortion has reached epidemic proportions in the United States. More than 1.5 million abortions are performed annually; one-third of these are performed on teenagers (including more than 15,000 abortions annually performed on girls age 14 and younger); and one-third of the total number of abortions annually are performed on women (including many teenagers) who previously have had one or more abortions. Abortion in the United States has become, in the last decade, just another (ho-hum) method of birth control.

At the same time, there is a growing body of scientific data that casts serious doubt on previous assumptions regarding the relative safety of abortions. Compelling evidence indicates that abortion involves significant risk for a woman's physical health, especially her future reproductive capacity, that are not associated with childbirth. Evidence of serious and widespread psychological sequelae now exists. At the same time, reports have surfaced all over this country, and studies have verified, that many women who have had abortions feel that they were mislead, misinformed, or uninformed about what an abortion entails, the facts of prenatal development, the physical and emotional consequences of abortion, the alternatives available to them, etc.

Perhaps the most important determination which the Court will make in this case will be its clarification of the mode and standard of judicial review that are required under the Due Process Clause of the Constitution to be applied to abortion regulations. The courts below, especially the Court of Appeals, failed to appreciate that abortion regulations (like Akron's limited parental consent restriction, informed consent provision, and waiting period requirement) which do not significantly burden or interfere with the woman's private right to choose and obtain abortion, are not subject to strict judicial scrutiny.

Akron's parental consent provision, limited to early adolscents, 14 years old or younger, is clearly distinguishable from the blanket parental consent provisions invalidated by this Court in other cases. There is unanimous agreement among child

development experts that the judgmental and other capacities of 13 and 14 year olds is profoundly different than that of older adolescents.

It is impossible to make a voluntary choice in ignorance and haste. Akron's informed consent requirements are necessary to insure that pregnant women receive full disclosure of all material information relating to their abortion decisions. Abortion counselors and clinics are not voluntarily making full disclosure. The Akron provisions are consistent with this Court's prior rulings regarding adequate counseling and informed consent.

Abortion involves the disestablishment of a developing parent-child relationship. Many women have gone to incredible extremes to recover custody of children they precipitously agreed to release for adoption. There is a compelling need for local authorities to ensure that a woman considering abortion is fully advised of the alternatives and consequences, and that she has time to consider her alternatives before taking the irrevocable step of destroying her unborn child *in utero*.

ARGUMENT

I. BEFORE SUBJECTING A PROPERLY ENACTED ABORTION REGULATION TO STRICT JUDICIAL SCRUTINY, A COURT MUST DETERMINE THAT IT SIGNIFICANTLY BURDENS OR SUBSTANTIALLY INFRINGES THE FUNDAMENTAL RIGHT OF ABORTION PRIVACY.

A. *A Determination That A Regulation Affecting Abortion Burdens Or Impinges Upon The Fundamental Right Of Abortion Privacy Must Be Made Before It Is Subjected To The Exacting Review Of Strict Judicial Scrutiny.*

Perhaps the most significant and far-reaching determination which the Court will make in this case will be its clarification of the appropriate standard and process of judicial review under the Due Process Clause as applied to abortion regulations. This has been a subject of confusion and source of error for the lower courts for nearly a decade.

In *Roe v. Wade*, 410 U.S. 113 (1973) the Court identified a new

"fundamental right." But in so doing, the Court did not suggest (nor has it ever suggested) that this right is entitled to greater judicial protection than other fundamental rights. Accordingly, before a court undertakes to subject a duly enacted abortion regulation to rigorous examination under the standard of strict judicial scrutiny, it must make the threshold determination that the law involved burdens or infringes upon the constitutionally protected fundamental right.

This approach has been followed by the Supreme Court for many years in cases dealing with other fundamental rights. See, e.g., *Gibson v. Florida Legislative Investigation Committee*, 372 U.S. 539, 545 (1963) ("infringe significantly"); *Bates v. City of Little Rock*, 361 U.S. 516, 524 (1960) ("significant encroachment"). In cases dealing with other aspects of the right of privacy this Court has clearly demonstrated that strict judicial scrutiny will only be triggered when the government enactment "significantly interferes with," *Zablocki v. Redhail*, 434 U.S. 373, 383, 388 (1978) or "significantly burdens," *Carey v. Population Services International*, 431 U.S. 677, 689 (1977), that fundamental right.

This approach has been consistently followed and clearly directed by this Court in its abortion decisions. In *Roe* the Court explained the standard of judicial review that would apply as follows: "Where certain 'fundamental rights' are involved, the Court has held that *regulations limiting these rights* may be justified only by a compelling state interest. . . ." 410 U.S. at 155. As authority for this statement, the Court cited seven prior decisions. In each of those cases the regulation that was subjected to strict scrutiny completely denied, *Kramer v. Union Free School District*, 395 U.S. 621 (1969); *Griswold v. Connecticut* at 381 U.S. 479 (1965), "substantially infringe[d]," *Sherbert v. Verner*, 374 U.S. 398, 406 (1963), "materially impair[ed]," *Eisenstadt v. Baird*, 405 U.S. 438, 446, (1972), "severely restrict[ed]," *Aptheker v. Secretary of State*, 378 U.S. 500, 507 (1964), "unduly infringe[d]," *Cantwell v. Connecticut*, 310 U.S. 296, 304 (1940), or severely "penalize[d] the exercise of," *Shapiro v. Thompson*, 394 U.S. 618 (1969) the fundamental right involved.

Justice Stewart, concurring in *Roe*, emphasized that a determination of infringement must precede application of the strict standard of judicial scrutiny when he wrote, "[I]t is difficult to

imagine a more complete abridgement of a constitutional freedom than that worked by the inflexible criminal statute now in force in Texas. *The question then becomes* whether the state interests advanced to justify this abridgement can survive the 'particularly careful scrutiny' that the Fourteenth Amendment here requires." 410 U.S. at 170 (Stewart, J., concurring) (emphasis added). *See also Doe v. Bolton*, 410 U.S. 179, 197, 198 (1973).

In *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the spousal consent requirement invalidated by the Court under the standard of strict scrutiny was characterized as giving husbands an absolute "veto" power over a woman's decision. 428 U.S. at 68, 74, 75. A saline amniocentesis prohibition was attacked, because it would "preclude virtually all abortions in the first trimester." 428 U.S. at 76. On the other hand, recordkeeping requirements apparently were not examined under the rigorous standard because they were "not abused or overdone" and had "no legally significant impact or consequences on the abortion decision." 428 U.S. at 81. *See also Bellotti v. Baird (I)*, 428 U.S. 132, 147 (1976) ("unduly burdens").

In *Maher v. Roe*, 432 U.S. 464 (1977), the Court began its analysis by observing that "[t]he central question in this case is whether the regulation 'impinges upon a fundamental right explicitly or implicitly protected by the Constitution.'" 432 U.S. at 471. The Court explained that limitations upon the public funding of abortions were not subject to strict judicial review. The abortion prohibitions involved in *Roe* were described, constrastingly, as "a complete abridgement," a "sweeping restriction" and "a stark example of impermissible interference with the pregnant woman's decision to terminate her pregnancy." 432 U.S. at 472. In other cases the Court had invalidated, under strict scrutiny, "other types of restrictions, *different in form but similar in effect* on the woman's freedom of choice." 432 U.S. at 473 (emphasis added). *See also* 432 U.S. at 481 (Burger, C.J., concurring).

In *Bellotti v. Baird (II)*, 443 U.S. 662 (1979), the plurality noted: "The question before us—in light of what we have said in the prior cases—is whether [the challenged abortion regulation] does not unduly burden the right to seek an abortion." 443 U.S. at 640 (opinion of Powell, J.). *See also* 443 U.S. at 654, 655

(Stevens, J., concurring).

In *Harris v. McRae,* 448 U.S. 297 (1980) the Court emphasized the need to begin its analysis with an examination of whether the regulation involved infringed a fundamental right. "*We address first* the appellee's argument that the Hyde Amendment by restricting the availability of certain medically necessary abortions under Medicaid *impinges* upon the 'liberty' protected by the Due Process Clause recognized in *Roe* . . . and its progeny." 448 U.S. at 312 (emphasis added). Concluding that it did not, the Court declined to subject the Hyde Amendment to strict scrutiny.

Finally, in *H.L. v. Matheson,* 450 U.S. 398 (1981), the Court began its analysis by first addressing the appellant's contention that "the statute violates the right to privacy recognized in our previous cases." 450 U.S. at 407. Justice Stevens added: "The fact that a state statute may have some impact upon a minor's exercise of his or her rights *begins, rather than ends, the constitutional inquiry.* Once the statute's impact is identified, it must be evaluated in light of the State's interests underlying the statute." 450 U.S. at 421 (Stevens, J., concurring) (emphasis added).

If the plain language and example of this Court's abortion decisions is not enough, the explicit analysis of the Court in *Carey v. Population Services International* settles the question unequivocally. There, after reviewing the abortion decisions, the Court observed: "The significance of these cases is that they establish that the same test must be applied to state regulations *that burden an individual's right to decide* to prevent contraception or termination of pregnancy *by substantially limiting access to the means of effectuating that decision* as is applied to state statutes that prohibit the decision entirely. Both types of regulations 'may be justified only by a compelling state interest. . . .'" 431 U.S. at 688 (emphasis added).

Occasional statements by the Court that abortion statutes are unconstitutional "because" they are unduly burdensome *see e.g., Maher,* 432 U.S. at 473; *Bellotti* (II), 443 U.S at 640, have only been a shorthand way of indicating that they are inadequately justified under the strict standard of judicial review that is required of statutes that unduly burden a woman's right of

privacy. The Court has been speaking elliptically, much the same way that judges and lawyers speak of statutes being unconstitutional because they "restict free speech" when what is meant is that the statutes are unconstitutional because they are unjustified by the type of compelling state interests and narrow draftsmanship that are required under the exacting standard of judicial scrutiny applied to laws that interfere with First Amendment freedoms.

B. *An Abortion Regulation Is Subject To Strict Judicial Scrutiny Only After There Has Been A Clear Showing That It Seriously Restrains Or Obstructs A Woman's Constitutional Right To Choose To Terminate Her Pregnancy.*

The major disagreement between the Court of Appeals below and the District Court regarding the standard of judicial review centered upon *how* the standard should be applied, not what the standard is. The District Court concluded that the requirement that a doctor disclose to the woman the particular risks of the abortion in her case and provide her with instructions for her post-abortion recovery, and the requirement that an abortion not be performed until the passage of 24 hours after a woman has been apprised of that information, did not unduly burden or significantly interfere with a woman's constitutional right to choose. *Akron Center for Reproductive Health, Inc. v. City of Akron*, 479 F. Supp. 1172, 1198-1200 (N.D. Ohio 1979). The Court of Appeals disagreed. *Akron Center for Reproductive Health, Inc. v. City of Akron*, 651 F.2d 1198, 1203-04 (6th Cir. 1981).

The disagreement between these two courts illustrates a need for this Court to clarify *how much or what degree of restriction* or regulation triggers strict judicial scrutiny. As Judge Kennedy of the Court of Appeals noted, a label such as "undue burden" does "no more than state a conclusion, it is not helpful in *reaching* a conclusion." 651 F.2d at 1231 n. 2 (Kennedy, J., dissenting in part.)

It is crystal clear from this Court's prior decision that an *absolute* denial of the right to choose an abortion triggers strict judicial scrutiny. *Roe*, 410 U.S. at 170 (stewart, J., concurring); *Planned Parenthood*, 428 U.S. at 68, 74; *Maher*, 432 U.S. at 472, 473. What is not clear is how close to a total prohibition the

regulation must be before the exacting standard of strict judicial scrutiny is triggered.

One way to clarify this matter is to reiterate the underlying presumptions. It is well established that properly adopted local regulations concerning matters of economic and social welfare come before the courts with the presumption of constitutionality. *Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977) (opinion of Powell, J.); *Dandridge v. Williams*, 397 U.S. 471 (1971); *Ferguson v. Skrupa* 372 U.S. 726 (1973); *Williamson v. Lee Optical* 348 U.S. 483 (1955); J. Nowak, R. Rotunda & J. Young, Handbook on Constitutional Law 67 (Supp. 1982).

A "presumption of constitutionality [is] afforded state statutes and traditional approval [is] given state classification if the Court can conceive of a 'rational basis' for the distinction . . . . " *Kramer*, 395 U.S. at 627, 628; *see also Eisenstadt*, 405 U.S. at 447 n. 7. This presumption is, of course, a rebuttable presumption. But until it is rebutted, it is valid and effectively shields the state from the onerous duty of satisfying (and the courts from the sensitive and risky task of applying) the exacting standards of strict judicial scrutiny.[1]

In the context of abortion, it is *especially* important that the courts require a showing of infringement or burden before subjecting the abortion regulations to strict judicial scrutiny. The decision of the First Circuit Court of Appeals in *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979), illustrates and explains this well. In that case, the Court of Appeals reversed

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[1]Another way of clarifying this matter is to distinguish between substantive and procedural regulation. The Supreme Court in *Roe* and its progeny has established that a state cannot adopt an exclusively anti-abortion substantive policy, "imposing its will by force of law" or by "government compulsion." *Maher*, 432 U.S. at 473, 476. But it can adopt procedural regulations restricting the way in which the substantive choices are implemented. Monopolistic substantive positions are subjected to strict judicial scrutiny, while procedural restrictions are not. Thus, a "complete abridgement" of the right to choose to terminate a pregnancy is impermissible, *Roe*, 410 U.S. at 170. But regulations which merely encourage alternative activities are not. *Maher*, 432 U.S. at 476. Unless the "sheer burden" of the procedural impediments makes them "similar in effect" to the exclusive substantive restriction, *Maher*, 432 U.S. at 473, procedural regulations will not be subject to strict judicial scrutiny.

a district court injunction against application of a Massachusetts clinic licensure law and regulations to first-trimester abortion clinics. The factual basis for the injunction was very scant.

> [N]o evidence was introduced as to the impact of these regulations on the ability of the facility to carry out its mission. Specifically, there was no evidence as to . . . compliance with all the licensure provisions would be so burdensome as to affect the availability of abortions . . . . Nor was there any evidence as to whether the provisions were reasonable health regulations . . . . Plaintiffs' position, which was accepted by the district court, is that such evidence is not required; the constitutional infirmity, they argue, stems from the very application of regulations of this type to first trimester abortions and is apparent from their face.

599 F.2d at 1100.

The Court of Appeals disagreed, emphasizing that the failure of the plaintiff's to produce evidence that the regulations had a prejudicial impact upon the fundamental right of privacy was fatal.

> Without evidence that the regulations are unreasonable in terms of protecting the public health and safety or that they will impact in some legally significant manner upon the availability of abortions, we cannot draw plaintiffs' conclusions . . . When confronting broadly-based, facially neutral regulations of this type, *a lay tribunal lacks both the knowledge and expertise to evaluate the question of burdensomeness on its own; evidence, including expert evidence, would be essential for this purpose. In the absence of such evidence, we can only assume that the regulations reflect a proper, and in the case of abortions, non-excessive exercise of the state's power to safeguard the general health, safety and welfare.*

559 F.2d at 1102.

Thus, as explained in one tretise on this subject:

> The threshold question that arises in legal analysis under the doctrine of abortion privacy is whether the challenged regulation unduly burdens the right of abortion privacy. The question of burdensomeness is a question of fact. The party challenging the regulation carries the burden of producing

> evidence showing that the challenged regulation infringes on the fundamental constitutional right. The state need not prove that the regulation does not burden the right of privacy. The law presumes the validity of the regulation and that presumption relieves the state of any duty to establish "non-burdensomeness" of a challenged regulation in the absence of any actual evidence of such a burdensome impact.

L. Wardle, The Abortion Privacy Doctrine 309 (1981). *See also id.* at 4, 42, 44.

Thus, to justify the application of strict judicial scrutiny more than passing difficulty or mere inconvenience must be shown. Only *"direct State interference* with the protected activity" triggers application of strict judicial scrutiny. *See Maher* 432 U.S. at 474, 477 n. 10. The fundamental right involved is the right to personally choose and effectuate abortion, *Roe* 410 U.S. at 153; *Maher,* 432 U.S. at 472-74; the regulation must curtail *that.* Thus, if the regulation creates excessive or inordinate hardship on access to abortion services, if it effectively destroys the volition of the woman, if it substitutes the will of the state for the will of the woman, if it deprives the woman of her right to choose, then the regulation will be subject to strict judicial scrutiny. Otherwise it will not. In short, only if the regulation is either "a complete abridgement" or "different in form *but similar in effect* on the woman's freedom of choice" will it be subject to strict judicial scrutiny. *Maher,* 432 U.S. at 473; *Carey,* 431 U.S. at 689; L. Wardle, *supra* at 309.

II. THE SOCIO-LEGAL CONTEXT IN WHICH THIS CASE ARISES IS SIGNIFICANT.

A. *This Country Is Experiencing An Abortion Epidemic.*

Since the Supreme Court declared that pregnant women have a right to abortion on demand (at least before viability) the incidence of abortion in the United States has shot up to epidemic proportions. The number of abortions performed annually has risen every year since the Supreme Court decided *Roe v. Wade,*

as the following chart illustrates.[2]

Year	*Number of Reported Abortions (Rounded to nearest thousand)*	*Increase in Number Over Previous Year*	*Increase Over Previous Year (In percent)*
1972	587,000		
1973	745,000	157,000	27
1974	899,000	154,000	21
1975	1,034,000	135,000	15
1976	1,179,000	145,000	14
1977	1,317,000	137,000	12
1978	1,410,000	93,000	7
1979	1,498,000	88,000	4
1980	1,554,000	56,000	2

In the eight years, 1973-1980, more than 9.6 million abortions were *reported* in America.

The most recent complete and generally available data on abortion in America is for the year 1980.[3] That year there were over 1.55 million reported abortions in the United States. Accounting for the unreported abortions, the number of actual abortions performed in America that year was approximately 1.63 million.[4] Abortion is now the most frequently performed operation in the

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[2]Henshaw, Forrest, Sullivan & Tietze, *Abortion Services In The United States, 1979 & 1980*, 14 Fam. Plan. Perspectives 1, 6, Table 1 (1982) [hereinafter "Henshaw"]. The figures for and the number of abortions performed in 1972 were taken, and the numerical and percentage increases in 1973 were derived, from Center For Disease Control Abortion Surveillance, Annual Summary, 1978, at Table 1 (1980). *See* L. Wardle & M. Wood, A. Lawyer Looks At Abortion 7-9 (1982).

[3]The most comprehensive and readily available statistics on abortion are compiled by the Alan Guttmacher Institute and published in Family Planning Perspectives. The Center for Disease Control publishes abortion statistics also, but the C.D.C. database is not as complete as the A.G.I. database. Some C.D.C. abortion reports have been 15% under-inclusive. *See* C. Tietze, Induced Abortion: A World Review, 1981, at 19-26 (1981).

[4]Henshaw, *supra* note 2, at 7. The authors of this article noted that their studies indicated that the number of abortions actually performed may be from 3-6% higher than the number reported. *Id.*

United States (triple the number of toncillectomy operations). [5] The number of abortions performed every year now exceeds the population of at least 16 states.

The ratio of abortions to known pregnancies was 300/1000 in 1980. That means that of every 1,000 known pregnancies (pregnancies that resulted in either a live birth or a reported abortion) in 1980, three hundred (or 30 percent) were terminated by abortion. Henshaw, *supra* note 2, at 6, Table 1. In some areas of the country, e.g., New York City and Washington, D.C., there are more abortions reported annually than live births. Center for Disease Control, Annual Summary, 1979 at 103 (1980). About one-third of all abortions are obtained by teen-age girls; women ages 20 to 24 obtain about another third.[6] Abortion ratios are higher for teen-age girls than any other age group of women.

The number and percentage of abortion repeaters have risen every year. Nearly one-third of the abortions in 1978 were performed on women who previously had one or more abortion. Henshaw, et. al., *supra* note 6, at 17, 18, Table 10.

Over 2,750 "facilities" performed abortions in 1980. Sixteen percent of these abortion providers performed 1,000 or more abortions that year. These large-volume abortion facilities ("abortion mills") performed more than 75% of all abortions in 1980. Henshaw, *supra* note 2, at 12, Table 6.

Almost ninety-one percent of all abortions are performed during the first trimester of pregnancy. About eight percent are performed between the thirteenth and twentieth weeks, and over one percent are performed after viability. *See* Henshaw, et. al., *supra* note 6, at 17, 18, Table 10.

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[5]*See supra* note 2, and accompanying text; McCormack, *Record Number of Americans Going Under Knife*, Nexis (United Press International Nov. 28, 1981). In fact, the UPI Health editor reported that in 1979 the number of abortions done by dilation and curettage alone exceeded the number of every other type of surgical procedure except biopsy. *Id.*

[6]The latest A.G.I. report on the characteristics of women undergoing abortin is for 1978. Henshaw, Forrest, Sullivan & Tietze, *Abortion In The United States, 1978*, 13 Fam. Plan. Perspectives 1, 17, 18, Tables 10 & 11 (1981) [hereinafter "Henshaw, et. al."].

B. *The Right of Abortion Privacy Is A Unique Right.*

It is important not to lose sight of the unique nature of the right involved and the activity protected. Virtually every abortion involves the destruction of human life *in utero*. The right of abortion privacy is not like just any old right, or even any old fundamental right; it is simply not a fungible thing. Because a woman "carries an embryo, and, later a fetus," abortion "is inherently different from marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education . . . ." *Roe*, 410 U.S. at 159. In this context, some regulations, e.g., waiting period requirements, informed consent provisions, and parental consent for immature adolscent requirements, assume a unique role they would not have if applied to other fundamental rights such as the freedom of speech, the freedom of religion, voting, etc. Indeed, the Court was recognized this before. In *Bellotti (I)* the Court emphasized that "not all distinctions between abortions and other procedures are forbidden." 428 U.S. at 149. And in *Maher*, the Court observed "the simple answer to the argument that similar regulations [requiring prior written request and prior written approval for reimbursement] are not imposed for other medical procedures is that such procedures do not involve the termination of potential life." 432 U.S. at 480.

C. *The Court Needs To Clarify General Principles For The Benefit Of The Lower Courts.*

At issue in the case before the Court, are conflicting perceptions of general, guiding principles of constitutional law. It is important to keep that in mind because the technical detail of the Akron Ordinances makes this case unique, in many respects. For this Court to write a technical opinion in which the decision of the Court were justified only in terms of the details of this regulation or the unique facts of this case would not contribute to the clarification of the law. Indeed, many of the problems that have arisen as the lower courts have struggled to apply the doctrine of abortion privacy— the inconsistency of some of their opinions and the extremism of some of their results—can be traced to their attempt to read generalities into results that were justified in terms of a particularly narrow set of facts involved in one of the Supreme Court abortion decisions. L. Wardle, *supra* at 308.

Ambiguity about the principles of law underlying this Court's decisions in the abortion cases has made it difficult for the lower courts to give consistent, principled analysis in the abortion cases that have come before them. The resulting departure from accepted standards of judicial analysis, decision making, and opinion writing have been widely noted and criticized. *See e.g., id.,* at xi-xiii; L. Wardle & M. Wood, A Lawyer Looks At Abortion 164-65 (1982); A. Cox, The Role of the Supreme Court of American Government 53 (1976); A. Bickel, The Morality of Consent 27-29 (1975); J. Nowak, et. al., *supra at* 630, 631 (1978); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade,* 82 Yale L.J. 9 20 (1973); Epstein, *Substantive Due Process By Any Other Name: The Abortion Cases,* 1973 Sup. Ct. Rev. 159 (1974); Bryn, *An American Tragedy: The Supreme Court on Abortion,* 41 Ford. L. Rev. 807 (1973).

III. THE CONSTITUTION DOES NOT PROHIBIT LOCAL AUTHORITIES FROM TREATING EARLY ADOLESCENTS DIFFERENT FROM OLDER ADOLESCENTS BY REQUIRING THAT GIRLS ONLY FOURTEEN YEARS OLD OR YOUNGER OBTAIN PARENTAL OR JUDICIAL CONSENT FOR AN ABORTION.

Neither court below analyzed Akron's carefully limited parental consent provision under any standard of scrutiny for constitutionality. Instead, the "analysis" of both courts was limited to noting that § 1870.05(B) of the Codified Ordinances of The City of Akron bears some similarity to abortion regulations invalidated in *Planned Parenthood* and *Bellotti (II),* and peremptorily concluding that it is unconstitutional also. This superficial examination—guilt by association—led the lower courts to an erroneous conclusion. In fact there are profound difference between §1870.05(B) and the Missouri and Massachusetts provisions, and any fair analysis will vindicate the constitutionality of § 1870.05(B).

A. *Regulations Restricting the Constitutional Rights of Minors Are Not Subject to Strict Judicial Scrutiny.*

Because of the special conditions and disabilities of minority, statutes restricting the exercise of fundamental constitutional rights by minors are subject to a less demanding standard of scrutiny than statutes restricting the exercise of the same rights

by adults. *Planned Parenthood*, 428 U.S. at 74; *Bellotti* (II), 443 U.S. at 633, 634. In *Carey v. Population Services International*, Justice Brennan explained that a statute burdening the fundamental privacy rights of a minor would be invalidated if the state failed to produce evidence ("more than a bare assertion") that the statute was "a *rational means* for the accomplishment of some *significant state policy* . . ." 431 U.S. at 696 (emphasis added).

> This test is apparently *less rigorous than the "compelling state interest" test* applied to restrictions on the privacy rights of adults . . . Such lesser scrutiny is appropriate both because of the States' greater lattitude to regulate the conduct of children. . . and because the right of privacy implicated here is "the interest in independence in making certain kinds of important decisions," . . . and the law has generally regarded minors as having lesser capability for making important decisions. . . .

431 U.S. at 693 n.15 (citatons omitted) (emphasis added).

Thus, even if the lower courts had determined that § 1870.05(B) infringed a fundamental right of 14 year old minors, they should have examined § 1870.05(B) under a middle standard of scrutiny.

B. *The Right of Abortion Privacy Does Not Extend to Immature Minors.*

In *Planned Parenthood* this Court invalidated a Missouri statute that required parental consent before an abortion could be performed on any unmarried woman under the age of 18. But the Court was careful to limit the scope of its holding in that case. "We emphasize that our holding . . . does not suggest that every minor, *regardless of age* or maturity, may give effective consent for termination of her pregnancy." 428 U.S. at 75. In *H.L.*, the Court reiterated this and emphasized: "There is no logical relationship between the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of abortion." 450 U.S. at 408. *See Planned Parenthood*, 428 U.S. at 105 (Stevens, J., dissenting in part).

The heart of the right of privacy articulated in *Roe* and its progeny is the ability to make an informed choice. The facts of pregnancy and its alternatives provide the setting in which the

right of privacy (choice) may be exercised. Exercise of the right of privacy depends upon the ability of the pregnant woman to comprehend her condition, the alternatives available to her, the consequences associated with each alternative, and on her capacity to exercise at least rudimentary cognitive and moral judgment. *See Planned Parenthood*, 428 U.S. at 67. If the pregnant woman lacks the capacity to understand the different alternatives, or to choose among them, it does not infringe upon her fundamental right of privacy (choice) for a law to require that some other person share in exercising that decision-making right. *See L. Wardle, supra* at 162-180. Thus, a statute preserving the joint decision-making authority of the parent of a pregnant immature girl considering the irreversible act of abortion is not unconstitutional. *Bellotti (II)*, 433 U.S. at 642; *See* 433 U.S. at 653-55 (Stevens, J., concurring).

C. *There Are Profound Differences Between The Maturity of Girls Fourteen Years Old or Younger, and Girls Sixteen or Seventeen Years Old.*

The parental consent provisions previously found unconstitutional by this Court applied indiscriminately to all minors, regardless of age or maturity. The Missouri law found unconstitutional in *Planned Parenthood* applied to all unmarried minor women who were below 18 years of age. 428 U.S. at 72, 85. Similarly, the Massachusetts judicial or parental consent scheme which was found to be unconstitutional in *Bellotti (II)* applied to all unmarried women under age 18. 443 U.S. at 625. However, the Akron ordinance is not a blanket parental consent requirement. Section 1870.05 only requires parental or judicial consent prior to the performance of an abortion on a girl 14 years of age or younger. And age, like maturity, is a distinction of constitutional significance. *Planned Parenthood*, 428 U.S. at 75.

It is not unreasonable for the law to presume that girls age 14 and younger who are pregnant are incapable of making an informed and mature decision regarding abortion without the supervision of a parent or judge. There are *exceptional* differences in judgment and capacity between early adolescent girls, age 14 and younger, and older adolescents, age 16 or 17.

The word "adolescent" comes from the Latin word meaning "to grow to maturity." E. Hurlock, Adolescent Development 2

(4th ed. 1973). Adolescence is a time of transition from the dependency of childhood to the independence of adulthood. "Guidance is essential if the transition is to be made successfully and with minimum psychological damage." *Id.* at 15. Unlimited freedom adds to the adolescent's already-present feeling of insecurity. *Id.* at 256.

Adolescence is a time of maturation, and adolescents in our culture go through many distinct stages of growth across a wide spectrum of personal development. It is universally recognized that there are *profound* differences between 13 and 14 year old adolescents and 16 or 17 year old adolescents with regard to moral development, intellectual development, personality development, physical development, cognitive development, self-concept, attitudes, beliefs, sex drives, interests, and dependence upon parents. *See* A. Gessell, F. Ilg, and L. Ames, Youth: The Years from Ten to Sixteen *passim* (1956); H. Bernard, Adolescent Development 175, 212, 250; Williams, *Puberty and the Phases of Adolescence* in Adolescence: The Crisis of Adjustment, 27, 29 (S. Meyerson, ed. 1975); J. Horrocks, The Psychology of Adolescence 32, 63-73, 92-96, 112-27, 251, 284, 291, 325; (4th ed. 1976); G. Learner and G. Spanier, Adolescent Development 22 (1980); L. Bates, Adolescent Rorsarch Responses: Developmental Trends From Ten to Sixteen Years, 8, 11, 288-96 (1959); W. Wattenberg, The Adolescent Years 15, 16 (2nd ed. 1973). There is overwhelming social science evidence that pregnant adolescent girls age 14 years or younger are in need of parental supervision especially regarding as profound a decision as whether or not to terminate a pregnancy.

D. *Requiring Parental or Judicial Concent Before An Abortion is Performed on a Girl Fourteen or Younger Clearly Promotes Significant State Interests.*

The Court of Appeals below noted that the plaintiff abortion clinic provides its services to girls as young as 12 years of age. 651 F.2d at 1201. The record in other cases reveals that girls as young as ten have sought abortions at clinics. *Planned Parenthood*, 428 U.S. at 72. In fact, approximately one percent of all abortions annually are performed on adolescents 14 years or younger—*i.e.*, more than 15,000 girls age 14 or younger obtaining

abortions *annually* since 1978. *See* Henshaw, et. al., *supra* note 6, at 17, Table 10.

The requirement of parental or judicial consent before the performance of abortions on girls this young satisfies the three needs that have traditionally justified the imposition of parental consent requirements upon minors. *Bellotti (II)* 443 U.S. at 634 (opinion of Powell, J.). First parental consent preserves a relationship that is essential to the well-being of early adolescents. The premature breaking or weakening of the bond between parents and adolescents can be very detrimental to the developmental well-being of the adolescent. "Court or agency intervention without regard to or over the objection of parents can only serve to undermine the familial bond which is vital to a child's sense of becoming and being an adult in his [or her] own right." Goldstein, *Medical Care For the Child At Risk: On State Supervention of Parental Autonomy,* 86 Yale L. J. 645, 650 (1977). *See further* J. Goldstein, A. Freud, and A. Solnit, Before the Best Interests of the Child, 101-06 (1979). Thus, the parental consent requirement is justified by "the importance of the parental role in childrearing." *Bellotti (II)* 443 U.S. at 634. *See further Meyers v. Nebraska,* 262 U.S. 390 (1923); *Pierce v. Society of Sisters,* 268 U.S. 510 (1925); *Parham v. J.R.,* 442 U.S. 584 (1979).

Second, the parental consent requirement insures that guidance and direction will come from an adult who has had, and who will continue for sometime to have, a custodial relationship with and concern for the child. As noted *infra* at 24, abortion is an exceptionally traumatic experience for adult women to cope with. Adolescents have a *particular* need for adult guidance in areas in which they have had no childhood experience to guide them. E. Hurlock, *supra* at 252. Ambivalence and confusion regarding the abortion decision are much greater for adolescents, generally, than they are for adult women, and they are even greater for younger adolescents than for older adolescents. *Id.*

One researcher reports:

> A decision to have an abortion was not an easy one . . . . One of the young women admitted getting off the table at the abortion clinic before the procedure began . . . .
>
> Attitudes about the acceptability of abortion also demon-

> strate the ambivalence of many [adolescents] who had abortions. Looking back to the time before the abortion, less than one-half approved of abortion at that time. . . . Less than one-quarter approved of it after the abortion.

Horowitz, *Adolescent Mourning Reactions to Infant and Fetal Loss*, 59 Social Casework 551, 557 (1981). *See further* Babikan and Goldman, *A Study in Teenage Pregnancy*, 128 Am. J. Psychiat. 755 (1971). Thus, the Akron Ordinance protects early adolescents against "their inability to make critical decisions in an informed, mature manner . . . ." *Bellotti (II)* 443 U.S. at 634.

Third, the requirement of parental consent protects very young minors against the profound consequences that follow a decision to have an abortion. Studies of adolescents reveal that the risk of emotional problems are even more severe for them than they are for adult women. One study reported that two-thirds of the adolescent pregnant patients "showed intense dependency needs." Babikian and Goldman, *supra* at 759 (1971). Another study reported that nearly one-third of the young women who had abortions

> showed moderate to considerable decline in psychosocial functioning five to seven months post-abortion as measured from the baseline of their reported adequate pre-pregnancy status. These young women, at initial follow-up, were suffering with a variety of specific symptoms of maladaptive behavior including *mild to moderate depressive episodes*, a variety of new *physical complaints* for which medical attention had not been sought, . . . *difficulty in concentrating* in school, *withdrawal* from previous social contacts, *lowered self-esteem* explicitly related to the pregnancy and abortion experience, a *newly begun promiscuous pattern in relationships with men*, and regression to more infantile modes of relatinships with parents. *These difficulties did not predate the pregnancy.*

Wallerstein, Kurtz, and Bar-Din, *Psychological Sequelae of Therapeutic Abortions in Young Unmarried Women*, 27 Arch. Gen. Psychiat. 828 (1972) (emphasis added). Adolescents with previous emotional difficulties "were found to be chronically distressed, in continued poor psychosociological health, and additionally burdened by the open, unassimilated pregnancy and abortion experience which they seemed unable to integrate." *Id.* at 831. The authors observed "that the young women in our

study have only a 50% chance of having mastered the pregnancy and abortion experience to the point of adequate closure and reconstruction of the previous state of psychosocial functioning at five to seven months post-abortion." *Id.* They concluded:

> Our single *most striking set of findings relates to the effects of the pregnancy and abortion experience upon the younger adolescents* in the 14-17 year age span. Consequent sympton manifestations, even when only transient, tended to be *more dramatic and more severe* in this younger group. . . . Even more, we were struck by the more *pervasive long-range effects* of the pregnancy and abortions experience upon these particular young women . . . . Overall it is clear that the pregnancy and abortion experience in the younger and less mature *is considerably heightened risk*, a point of potential major maturational skewing.

Id. at 832. (emphasis added). See also Perez-Reyes and Falk, *Follow-up After Therapeutic Abortion in Early Adolescence*, 28 Arch. Gen. Psychiat. 120, 124 (1973), and studies cited in Horowitz, *supra* at 553 n.10.

One of the particular difficulties for adolescents is the problem of dealing with the very real sense of loss after an abortion is performed.

> A major task of adolescence is the detachment from parental figures. There are similarities between the course of this separation and the mourning process [that follows abortion]. . . . 'Normal adolescent mourning,' as Max Sugar calls the process of separating from parental figures, makes adolescents vulnerable to other losses. Some loss of support to the adolescent ego and superego have already resulted from this process. With futher losses, the threat to an adolescent's identity can be strong.

Horowitz, *supra* at 552. Less than one-fourth of the adolescents

observed completed a healthy adaptive mourning process.[7]

Adolescents who do not fully address this emotional problem face greater risk of subsequent pregnancy. "They *tended to conceive again soon after the termination of the previous pregnancy.* Many of the young women showed few mourning reactions, perhaps because of a fear of being overwhelmed by their responses and because few others supported their expression of these feelings." *Id.* at 558 (emphasis added).

> Working through a loss is often a painful process, but failure to do so increases the likelihood that feelings about this loss will influence a young woman's feeling about herself, a subsequent child, and future separations and losses . . . . Working through a loss can be difficult, while becoming pregnant again may seem to be a simple solution.

Id. at 559. "Conceiving again at a median of . . . nine and one-half months for the Abortion Group suggest that many may have had difficulty accepting the previous loss. Twenty-five said that they purposely became pregnant again as a replacement of the previous loss. Thirteen did not admit planning the subsequent pregnancy, but avoided contraceptives even though they were aware of the consequences of doing so." *Id.* at 556.

This may explain the phenomenon of the rising incidence of repeated abortions.[8] One study showed that 17% of the women

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[7]Horowitz, *supra* at 553.

> The young woman's initial period of shock and denial of the loss is normally followed by reactions such as fantasizing about the baby; expressing the need to see if it is possible to have another child; feeling guilty about her own role in the loss; feeling angry toward the hospital personnel, family, or the baby's father; and having somatic reactions. These responses are sometimes followed by a period of pain and despair, in which apathy is common. A teenager may show a lack of caring for herself and her future. This sometimes serves as punishment for her perceived role in the loss.

Id.

[8]In 1976 one-fourth of all abortions were repeat abortions. Teitze, *Repeat Abortions: Why More,* 10 Fam. Plan. Perspectives 286 (1978). In 1977 the percentage was even higher. The percentage of teenagers obtaining abortions who previously have had an abortion is estimated to be 5% for girls aged 15, and this figure rises by 5% with every age-year until 25% of the teenagers aged 19 having abortions have previously had one or more abortions. Teitze, *supra* 10 Fam. Plan. Perspectives at 205.

under 18 who had abortions were pregnant again within one year. Steinhoff, et al., *Women Who Obtain Repeat Abortions: A Study Based On Record Linkage*, 11 Fam. Plan. Perspectives 30, 37 (1979). Another study showed that 41% of adolescents who had therapeutic abortions had resumed sexual intercourse six months later, more than two-thirds of whom were then doing so without contraceptives. Perez-Reyes, et al., *supra* at 123.

Thus, the parental consent requirement for early adolescents of the Akron Ordinance is designed to prevent the exploitation of "the peculiar vulnerability of children . . . ." *Bellotti (II)*, 443 U.S. at 634. Clearly, the Akron Ordinance promotes significant governmental interests in families, parents, and children, and should be upheld.

IV. THE AKRON INFORMED CONSENT AND WAITING PERIOD REQUIREMENTS DIRECTLY PROMOTE COMPELLING GOVERNMENTAL INTERESTS CONCERNING THE WELFARE OF PREGNANT WOMEN.

Akron's informed consent and waiting period requirements do not significantly burden the fundamental right of abortion privacy. In this respect, the central question is not whether informed consent and waiting period requirements will reduce the likelihood that pregnant women will choose to have abortions, but whether or not the regulations inhibit the right of such women to make informed decisions "whether *or not*" to have an abortion. If a woman is not told of the facts of fetal development and the alternatives available to her ("the most significant consequences of the [abortion] decisions are not medical in character," *Planned Parenthood*, 428 U.S. at 103), of the proposed method of abortion and its particular risks for her, and if she is not protected against being rushed into a decision, it could not be said that her abortion was the result of the kind of deliverate personal choice that the constitutional right of privacy encompasses. Clearly, the Akron ordinances do not significantly interfere with the fundamental right to choose to terminate pregnancy. Moreover, even if a compelling state interest were required, the informed consent and waiting provisions would be constitutional because they are carefully drafted to effectuate compelling governmental interests in the health of pregnant women.

A. *Abortion Entails Serious Risks For A Woman.*

This Court has recognized that: "The medical, emotional, and psychological consequences of an abortion are serious and can be lasting . . . ." *H.L.*, 450 U.S. at 411. "Abortion is associated with an increased risk of complications in subsequent pregnancies." *H.L.*, 450 U.S. at 411 n.20. A subcommittee of the U.S. Senate has investigated, and rejected, the notion that abortion is generally safer than childbirth. S. Rep. No. 97-465, 97th Cong., 2d Sess. 35, 36, 39 (1982). "There is now compelling evidence that some severe, long-lasting medical complications occur more frequently following abortion than childbirth, as even some proabortion writers appear to acknowledge." L. Wardle & M. Wood, *supra* at 112. There is a clear correlation between abortion and future reproductive health problems for the woman. [9]

Equally important is the evidence of serious psychological consequences of abortion. It has long been recognized that most women make the decision to have an abortion with anxiety, ambivalence, and distress. But there is a growing evidence "that the ordinary feelings of distress and anxiety associated with abortion are only the tip of the iceberg." S. Rep. No. 97-465 at 41.

One psychologist testifying before a Senate subcommittee

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[9] There is an undisputed correlation between abortion and future reproductive health problems for the woman. For example, a Boston study indicated that the risk of subsequent miscarriage rated from 2.3 to 3.3 times greater for women who had more than one abortion than for women who had one or none. Levin, Schoenbaum, Monson, Stubbelfield, & Ryan, *Association of Abortion With Subsequent Pregnancy Loss*, 243 J.A.M.A. 295 (1980). A California study suggested that women who had one abortion had 1.8 times greater risk of miscarriage in the next pregnancy than women who had no abortions, and women who had two or more abortions had 3.1 times greater risk of miscarriage. Harlap, Shiono, Ramcharan, Berendes & Pellegran, *A Proposed Study of Spontaneous Fetal Losses After Induced Abortions*, 301 New Eng. J. Med. 677 (1979). Doctors at Vanderbilt University recently reported finding a seven to fifteen-fold increase in placenta previa in women who have had first-trimester abortion (placenta grows across the womb; serious bleeding and risk of death formother and child if caesarean section not performed). Barrett, Boehm & Killam, *Induced Abortion: A Risk Factor for Placenta Previa*, 141 Am. J. Obstet. Gynecol. 769 (1981). *See also* Lembrych, *Fertility Problems Following Aborted First Pregnancy* in New Perspectives on Human Abortion 128 (T. Hilger, D. Horan, & D. Mall eds. 1981).

referred to 34 "different studies on psychological effects of abortion showing that 'the negative potential reactions span anxiety and depression to psychosis and suicide.'" S. Rep. No. 97-465, at 42.

The authors of one recent study declared: "We have produced evidence that abortion does precipitate severe mental illness, particularly in vulnerable women but by no means exclusively." Simm & Neisser, *Post-Abortive Psychoses: A Report From Two Centers* in The Psychological Aspects of Abortion, 18 (D. Mall & W. Watts eds. 1979). *See also* Spaulding & Cavenar, *Psychosis Following Abortion,* 135 Am. J. Psychiatry 364 (1979). Significantly recurring psychological sequelae identified by two other researchers include guilt, anxiety, depression, sense of loss, anger, change in relationship with boyfriend, crying, and feeling mislead by misinformation or lack of information. Liebman & Zimmer, *The Psychological Sequelae of Abortion: Fact and Fallacy* in The Psychological Aspects of Abortion, *supra* at 127, 131. The Council of the Royal College of Obstetrics and Gynecology in Great Britain reported in 1966: "The incidence of serious premanent psychiatric aftermath [from abortion] is variously reported as being from nine and 59%" Quoted in J. Willke, Handbook on Abortion 49, 50 (1975).

B. *Anxiety About Abortion is Reduced if All Material Information Regarding Her Condition, The Alternatives, Consequences, And Risks Have Been Disclosed To The Woman.*

One of the factors that heightens preabortion anxiety is uncertainty. Full disclosure alleviates this cause of anxiety. It also provides the attending physician with an opportunity to assess the mental state of the patient. "Discussion of the risks of surgery will reveal the level of anxiety of the patient about his or her illness and impending surgery." Rockwell & Pepitone-Rockwell, *The Emotional Impact of Surgery and The Value of Informed Consent,* 63 Med. Clin. of N. Am. 1341, 1344 (1979).

As a general rule, "The *more elective a procedure is, the more important full disclosure becomes.*" G. Annas, The Rights of Hospital Patients, 60 (1975) (emphasis in original). Most patients want more, not less, information. One study of 900 patients about to undergo angiography had patients review and sign a consent

form that "detailed a number of serious reactions, including possible loss of an organ, a death rate of four in 6,500, and the complication rate of one in 500." *Id.* at 62. Over 75 % of those surveyed considered the information useful, and over 70% either felt more comfortable or were not emtionally affected. *Id.* citing Alfidi, *Informed Consent* in Complications and Legal Implications of Radiologic Special Procedures (Meaney et. al. eds., (1973). *See futher* Alfidi, *Informed Consent,* 216 J.A.M.A. 1325 (1971) (smaller sample, similar results).

C. *Failure To Make Complete Disclosure Heightens The Risk of Negative Postabortion Psychological Sequelae.*

"How a woman copes with abortion will partially depend on her knowledge about the procedure and the attitudes and reactions of others. If abortion is discussed in *careful detail* as a medical procedure without disgust or shame, the woman can cope more effectively with the experience." Smith, *Counseling For Women Who Seek Abortion* in Abortion: The Emotional Implications 75, 82 (R. Kalmar ed. 1977) (emphasis added). Informed consent discussions "can reduce chances of a maladapted post-operative course."[10]

One of the frequently recurring psychological sequelae of abortion is that women "feel misled by misinformation or lack of information." Liebman & Zimmer, *supra* at 131. These authors reported:

> Ten women [of 58 constituting the sample study] felt misled by persons they went to for help after the abortion. Part of them felt they were given misinformation. Women were told their pregnancy was "like a fish," "like an acorn," or "only

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[10]Rockwell, et. al., *supra* at 1342.

> [T]he informed consent discussions serve to provide three major ways that patients and physicians can reduce chances of a maladaptive post-operative course. First, discussion of the risk and benefit helps the patient prepare emotionally for a bodily-intrusive event. Second, allowing the patient to know what can be predicted post-operatively enhances the patient's sense of control. Maslow notes that what you do not know has power over you while knowledge brings control and choice. "'Ignorance makes choice impossible." . . . Finally, telling the patient how the physician and hospital staff will be helpful during the post-operative course will provide the patient with realistic expectations of the staff."

> tissue." When one woman voiced her concern at the clinic that the abortion might be killing, the counselor said: "Don't think of it as a killing. Think of it as taking blood out of your uterus to get your periods going again." When another called the clinic after the abortion to discuss her post-abortion emotional distress, she was told "only 2% of the women feel like this." Five in this category verbalized their dismay at the lack of information they were given. Women said they were upset because they were not informed of the possibility of miscarriage, of sterility, or of post-abortion emotions. In addition, two of them were resentful that they were not given alternatives.

Id. at 133.

The members of *Amicus* Women Exploited are living proof of the seriousness of this problem. Women across the country feel that they were misled, misinformed, and deceived by the lack of full disclosure regarding the facts of prenatal life and the emotional and physical sequelae of abortion. Often their experience surfaces long after the abortion in an overwhelming, traumatic fashion. *See* S. Rep. No. 97-465 at 42. Informed consent laws, like the Akron Ordinances, are designed to protect the rights of these women and their sisters for whom full disclosure may make a difference in deciding whether or not to have an abortion. Even if disclosure is redundant for some—even most—women seeking abortions, the Akron informed consent provisions are justified—indeed, essential—to protect the rights of more distressed or less informed women. (The fact that one-third of all abortions are performed on teenagers underscores the need for such "consumer protection" laws.)

D. *Abortion Counselors And Clinics Are Caught in a Conflict of Interests That Inhibits Their Voluntarily Making Full Disclosure.*

Most abortions are performed by individuals who are unknown to the woman and who are directly interested in the outcome of her decision regarding abortion. Abortion counselors and physicians often have a financial and emotional stake in persuading a woman to choose to have an abortion. *See e.g.*, Auerback, *Abortions: Now It's Big Business* in Hearings on S. J. Res. 119 and S. J. Res. 130

Before the Subcomm. on Constitutional Amendments of the Senate Committee on the Judiciary, 93d Cong. 2d Sess. 468 (1976); Connor, *Liberal Abortion Law Proves to Be a Bonanza for New York Doctors*, in *id.* at 470.

Abortion clinics are not voluntarily providing women with the kinds of information they need to make a careful and reasoned decision. *See* Wood & Durham, *Counseling, Consulting, & Consent: Abortion and The Doctor-Patient Relationship* 1978 B.Y.U. L. Rev. 783, 784. One study of 46 women who had abortions at one clinic revealed that 31 of them "either had no knowledge about abortion or were misinformed about the procedure." Smith, *supra* at 78. *See also* Liebman & Zimmer, *supra* at 131-133.

It is ironic that despite the tremendous protection afforded the abortion industry by the decisions of this Court, that industry has not responded to the Court's encouragement to take the responsibility to counsel patients seriously. The record in this case (651 F.2d at 1201) reveals that the nature and amount of counseling done by the plaintiff clinic is no better than that noted critically by Justice Steward more than five years ago. *Planned Parenthood*, 428 U.S. at 91 n.2 (Stewart, J., concurring).

E. *Requiring Disclosure of The Facts Of Fetal Development By A Physician And a Mandatory Cooling Off Period Are Essential To Protect A Woman's Right To Make An Informed Decision.*

In *Roe* the Court emphasized its expectation that "consultation" would occur between a woman and her physician during which time the abortion decision would be made. 410 U.S. at 153, 162, 163, 164, 166. Participation by the attending physician in the abortion decision was reiterated in later decisions as well. *Planned Parenthood*, 428 U.S. at 61. *Collautti*, 439 U.S. at 387.

Participation by the physician in the informed consent process is crucial. At the very least, the patient needs to have the opportunity to ask questions of her attending physician before making her decision regarding abortion. *See Rockwell* et. al., *supra* at 793, 830; L. Wardle & M. Wood, *supra* at 107-111.

Nevertheless, the practice of the plaintiff abortion clinic does not even come close to the model described by this Court. None of

the persons advising the woman regarding her abortion decision is a physician, and her first contact with the physician who is to perform the abortion "usually occurs when she is taken into the operating room." 651 F.2d at 1201.

Of course, to require the participation of a physician in the informing process could result in a slight increase in the cost of th abortion services. But there are more severe costs—both for the woman and for the constitutional ideal of informed consent—if physician participation in the decision-making stages does not occur.

A decision to have an abortion, made without knowledge of the facts of fetal development, could not under any stretch of the imagination be deemed an informed decision. In the absence of laws requiring the disclosure of the facts of fetal development, the clinic or doctor may be able to perform the obligation of informing the woman about abortion by describing the procedure as nothing more than the removal of a benign growth. To be sure, regulations that are unnecessarily punitive or that are clearly designed to increase the stress of the woman undergoing abortion (e.g., requiring her to view grossly explicit slides of dismembered aborted fetuses) would not be sustainable under any standard of judicial review. But to require that a woman be dispassionately informed about the facts of fetal development before deciding whether or not to have an abortion enhances, rather than interferes with, her right to make an informed decision.

A 24 to 48 hour waiting period requirement does not infirnge upon the fundamental right of privacy. The abortion decision, like the decision to release a child for adoption, *disestablishes a parent-child relationship.* That relationship is as sensitive and as powerful as any known to the law. The termination of that relationship historically has been subject to safeguards. Experience has shown that many a woman has changed her mind and gone to incredible lengths to recover a child she released for adoption. Many states, including Ohio, require that a woman wait at least 72 hours after the birth of a child before giving a valid consent to adoption. Ariz. Rev. Stat. § 8-107(B) (1974); Ill. Ann. Stat. ch. 4 § 9.1-9(B) (Smith-Hurd 1975); Ohio Rev. Code Ann. § 3107.8 (page 1980). In Virginia, consent for adoption cannot be given until the child is at least ten days old. Va. Code § 63.1-25 (1982). Of course, after an

abortion a woman who changes her mind cannot recover her child. Thus, there is compelling justification for a law which establishes a 24 or 48 hour "cooling off period" before a decision to have an abortion is implemented.

V. CONCLUSION

For nearly a decade, the abortion decisions of this Court have been the subject of great controversy. Not only has there been widespread public misunderstanding of the decisions, but within the federal judiciary they have been misunderstood. While the opinions of this Court have drawn some very subtle distinctions, it is apparent that the lower courts have been much more impressed by what they think the Court is doing (invalidating most abortion regulations) than by what the Court has been saying (about finding that the fundamental right to choose is really burdened before applying strict scrutiny).

The Akron ordinances were adopted more than five years after *Roe v. Wade* was decided by this Court. Drawing upon a half-decade of judicial construction of the right of abortion privacy—including six subsequent abortions opinions of this Court—the Akron ordinances were carefully, painstakingly drafted to comply with the principles of constitutional law that those decisions established. The Akron ordinances were designed to regulate abortion practice without restricting choice, to assert strongly held, important governmental interests without interfering with a woman's right to decide whether or not to have an abortion.

The decision of the Court of Appeals invalidating the limited parental consent requirements, the informed consent provisions, and the brief waiting period requirement failed to properly apply the standard of constitutional review established by this Court, and the judgment holding sections (1870.05(B), 1870.06, and 1870.07 unconstitutional should be reversed.

Respectfully submitted,

Lynn D. Wardle
Counsel for Amici
United Families Foundation
and Women Exploited

CERTIFICATE OF SERVICE

State of Utah)
) ss
County of Utah)

I, Lynn D. Wardle, counsel for the *amici curiae*, being a member of the Bar of the Supreme Court of the United States, do hereby certify that all parties required to be served have been served with three copies of this brief by depositing the same in a United States Post Office with first class postage prepaid, addressed to:

Robert D. Pritt
Director of Law
304 Municipal Bldg.
Akron, Ohio 44308
Counsel of Record for Petitioners

Stephen Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
Counsel of Record for Respondents

Alan Segedy and Robert Destro
40 East Mill Street
Akron, Ohio 44301
Counsel for Intervenor

Signed this 9th day of July, 1982.

LDW

Lynn D. Wardle
518 JRCB
Brigham Young University
Provo, Utah 84602
801/378-2617

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CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH INC., et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF AMICUS CURIAE OF WOMANKIND, INC. IN SUPPORT OF PETITIONER, CITY OF AKRON

Counsel for Amicus
JAMES ARTHUR GLEASON 216-771-5466*
The Park Building
149 Public Square
Cleveland, Ohio 44114

MARY ANN JOHANEK 216-447-9050
Two Rockside, 77 Center
6000 N. Creek Rd., Suite 15
Independence, Ohio 44131

THOMAS J. KEENAN 216-566-7550
Statler Office Tower, Suite 870
Cleveland, Ohio 44115

JOSEPH P. MEISSNER 216-687-1900
1223 W. Sixth St.
Cleveland, Ohio 44113

Of Counsel:
Americans United For Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, IL 60601
312/263-5029

*Counsel of Record

July 29, 1982

UNITED STATES LAW PRINTING CO., CHICAGO, ILLINOIS 60618 (312) 525-6581

TABLE OF CONTENTS

Table of Authorities iii

Interest of the Amicus Curiae 1

Summary of Argument 2

Argument 5

I. Consideration Of The Controversy Between The "Physician Paternalism" And The "Patient Autonomy" Approaches To General Informed Consent Doctrine Is Critical In Deciding The Constitutionality Of The "Informed Consent" Provisions Of The Akron Ordinance 5

II. Medical Treatment Requires The Consent Of The Patient, And The Universal Modern Rule Is That The Consent Must Be Informed 7

III. The Older "Physician Paternalism" Approach Has Been Replaced By The Newer "Patient Autonomy" Approach In Ohio And A Substantial Number Of Other States 8

IV. The Akron Ordinance Applies The "Patient Autonomy" Approach To Abortion 12

V. From A "Patient Autonomy" Perspective, There Is Ample Precedent And Reason For Providing No "Therapeutic Exception" In The Akron Ordinance 17

PAGE

VI. Well-Publicized Abuses By Abortion Clinic Physicians And Counselors Make It Particularly Appropriate For Legislatures To Prefer The "Patient Autonomy" To The "Physician Paternalism" Approach In Applying The Informed Consent Doctrine To Abortions 22

VII. The Constitution Should Not Be Interpreted To Preclude Reliance On The "Patient Autonomy" Approach When States Act To Protect The Right Of Women To Give Informed Consent To Abortion 27

Conclusion 29

Appendix: Notes To Table Of Current Positions On The Approach To Informed Consent By State ..... App. 1

TABLE OF AUTHORITIES

Cases

PAGE

Aiken v. Carey, 396 S.W. 2d 668 (Mo. 1965) .....App. 4

Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198 (6th Cir. 1981) 2, 5, 22

Arneson v. Alsen, 270 N.W.2d 125 (N.D. 1978) .....App. 5

Bennett v. Graves, 357 S.W.2d 893 (Ky. Ct. App. 1977) App.3

Bly v. Rhonds, 216 Va. 645, 222 S.E.2d 783 (1976) ..App. 6

Bowers v. Talmadge, 159 So.2d 888 (Fla. Dist. Ct. App. 1964) .....App. 2

Bruni v. Tatsumi, 46 Oh.St.2d 127, 346 N.E.2d 673 (1976) 12

Butler v. Berkeley, 25 N.C.App. 325, 213 S.E.2d 571 (Ct. App. 1975) .....App. 5

Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972) .....9, 10, 12 16, 17, 19, 27, App. 2

Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) App. 4

Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) 5, 21

Cobbs v. Grant, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) .....18, App. 1

Coleman v. Garrison, 349 A.2d 8 (Del. 1975) .....App. 2

Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E.2d 765 (Comm. Pleas 1973) .....6, 12, App. 5

Cooper v. Roberts, 220 Pa. Super. 260, 236 A.2d 647 (1971) .....App. 5

Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955) ....App. 4

PAGE

Cornfeldt v. Tongren, 262 N.W.2d 684 (Minn. 1977) App. 4

Cunningham v. Yankton Clinic, 262 N.W.2d 508 (S.D. 1978) ..... App. 6

Ditlow v. Kaplan, 181 So. 2d 226 (Fla. Dist. Ct. App. 1965) ..... App. 2

Doe v. Bolton, 410 U.S. 179 (1973) 16

Dunham v. Wright, 423 F.2d 940 (3rd Cir. 1970) 18

Ficklin v. MacFarlane, 550 P.2d 1295 (Utah 1976) ..App. 6

Folger v. Corbett, 118 N.H. 737, 394 A.2d 63 (1978) ..App. 4

Govin v. Hunter, 374 P.2d 421 (Wyo. 1962) ..... App. 6

Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966) ..... App. 3

Green v. Hussey, 127 Ill. App.2d 174, 263 N.E.2d 156 (App. Ct. 1970) ..... App. 3

Haggerty v. McCarthy, 344 Mass. 136, 181 N.E.2d 562 (1962) ..... App. 4

Harris v. McRae, 448 U.S. 297 (1980) 27

Henning v. Parsons, 95 N.M. 454, 623 P.2d 574 (1981) App. 4

Holland v. Sisters of St. Joseph of Peace, 270 Or. 129, 622 P.2d 208 (1974) ..... App. 5

Holton v. Pfingst, 534 S.W.2d 786 (Ky. 1975) ..... App. 3

Joy v. Chau, 377 N.E.2d 670 (Ind. Ct. App. 1978) ..App. 3

Jeffries v. McCague, 242 Pa. Super. 76, 363 A.2d 1167 (Super. Ct. 1976) ..... App. 5

Kaplan v. Haines, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd* 51 N.J. 404, 241 A.2d 235 (1968) ....App. 4

Karlsons v. Guerinot, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App. Div. 1977) ..... App. 5

PAGE

Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974) .....App. 6

Kinikin v. Heupel, 305 N.W.2d 589 (Minn. 1981) 18

Lambert v. Park, 597 F.2d 236 (10th Cir. 1979) ....App. 5

Leigh v. Olson, 497 F. Supp. 1340 (D.N.D. 1980) 5

LePlelley v. Grefenson, 101 Idaho 422, 614 P.2d 762 (1980) .....App. 2

Lochner v. New York, 198 U.S. 45 (1905) 29

Longmire v. Hoey, 512 S.W.2d 307 (Tenn. Ct. App. 1974) .....App. 6

Maher v. Roe, 432 U.S. 464 (1977) 7, 16, 27

Mallett v. Pirkey, 171 Colo. 271, 466 P.2d 466 (1970) .....App. 1

Martin v. Stratton, 515 P.2d 1366 (Okla. 1973) ....App. 5

Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (Ct. App. 1974), *aff'd* 85 Wash.2d 151, 530 P.2d 334 (1975) .....14, 16, App. 6

Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960) .....9, App. 3

Negaard v. Estate of Feda, 152 Mont. 47, 446 P.2d 436 (1968) .....App. 4

Nishi v. Hartwell, 52 Hawaii 188, 473 P.2d 116 (1970) .....App. 2

Patrick v. Sedwick, 391 P.2d 453 (Alaska 1964) ....App. 1

Percle v. St. Paul Fire and Marine Ins. Co., 349 So.2d 1289 (La. Ct. App. 1977) .....App. 3

Planned Parenthood Association v. Fitzpatrick, 401 F.Supp. 554 (E.D. Penn. 1975), *aff'd in relevant part*, 428 U.S. 901 (1976) 23

PAGE

Planned Parenthood Association of Kansas City, Mo. v. Ashcroft, 655 F.2d 848 (8th Cir. 1981) 5, 21

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 29

Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1981) 14, 20-21

Plutshack v. Univ. of Minn. Hospitals, 316 N.W.2d 1 (Minn. 1982) ..... App. 4

Poulin v. Zoitman, 542 P.2d 251 (Alaska 1975) ..... App. 1

Regram v. Sisco, 406 F. Supp. 776 (W.D. Ark. 1976) ..... App. 1

Roberts v. Wood, 206 F. Supp. 579 (S.D. Ala. 1962) ..... App. 1

Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963) ..... App. 4

Roe v. Wade, 410 U.S. 113 (1973) 15, 29

Ross v. Hodges, 234 So.2d 905 (Miss. 1970) ..... App. 4

Salgo v. Stanford University Bd. of Trustees, 154 Cal. App.2d 560, 317 P.2d 170 (Ct. App. 1957) 8

Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (Ct. App. 1977) ..... 10, App. 3

Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914) 8

Schroeder v. Lawrence, 372 Mass. 1, 359 N.E.2d 1301 (1977) ..... App. 4

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PAGE

Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (Ct. App. 1965) ..... App. 1

Small v. Gifford Memorial Hospital, 133 Vt. 552, 349 A.2d 703 (1975) ..... App. 6

Torres Perez v. Hospital Doctor Susoni, 95 P.R.R. 845 (1968) ..... App. 5

Trogun v. Fruchtman, 58 Wis.2d 569, 207 N.W.2d 297 (1973) ..... App. 6

Walker v. North Dakota Eye Clinic, 415 F. Supp. 891 (D.N.D. 1976) ..... App. 5

Walker v. Pierce, 560 F.2d 609 (4th Cir. 1977) ..... App. 6

Whalen v. Roe, 429 U.S. 589 (1977) 28

Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972) ..... 14, App. 6

Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967) ..... App. 6

Woolley v. Henderson, 418 A.2d 1123 (Me. 1980) ..9, App. 3

Young v. Yarn, 136 Ga. App. 737, 222 S.E.2d 113 (Ct. App. 1975) ..... App. 2

Statutes and Regulations

Akron, Oh. Codified Ordinance §§1870.06(B)(1) and (2) 13

Akron, Oh. Codified Ordinances §§1870.06(B)(3) and (4) 14

Akron, Oh. Codified Ordinances §1870.06(B)(5) 13

Akron, Oh. Codified Ordinances §1870.06(B)(7) 1, 13

Alaska Stat. §09.55.556 (Supp. 1981) ..... App. 1

Del. Code Ann. tit. 18, §§6851-6852 (Supp. 1980) ....App. 2

PAGE

Fla. Stat. Ann. §768.46 (West Supp. 1982) ..... App. 2

Ga. Code Ann. §§ 88-2901 to -2907 (1979) ..... App. 2

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Idaho Code §§39-4301 to -4306 (1977) ..... App. 2

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Ky. Rev. Stat. Ann. §§304-40-320 (Baldwin 1981) ..... App. 3

La. Rev. Stat. Ann. §40:1299.40 (West 1977) ..... App. 3

Me. Rev. Stat. Ann. tit. 24, §2905 (Supp. 1981-82) ..... App. 3

Minn. Stat. Ann. §144.651 (West Supp. 1982) ..... App. 4

N.C. Gen. Stat. §90-21.13 (1981) ..... App. 5

N.D. Cent. Code §26-40.1-04 to -05 (1978) ..... App. 5

N.H. Rev. Stat. Ann. §507-C (Supp. 1981) ..... App. 4

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Tenn. Code Ann. §29-26-118 (1980) ..... App. 6

3 Tex. Reg. 4293 (1978) ..... 28, App. 6

Tex. Rev. Civ. Stat. Ann. art. 4590 §§6.03-.07 (Vernon Supp. 1982) ..... 28, App. 6

PAGE

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PAGE

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In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 81-746

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH INC., et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF AMICUS CURIAE OF WOMANKIND, INC.

INTEREST OF THE AMICUS CURIAE

Womankind, Inc. is a charitable nonprofit community service in the Cleveland, Ohio area which has been providing women who have untimely pregnancies with counseling and assistance since 1975. Womankind affords three interrelated kinds of emergency pregnancy service: 1) crisis intervention counseling, 2) pre-natal infant and maternal health care services (Womankind operates the only medical clinic of this kind in the State of Ohio, with free medical care offered by a volunteer staff of licensed physicians, registered nurses, and technicians), and 3) long-term counseling, educational and supportive programs. Womankind support programs include psychiatric counseling, legal assistance, pre-natal medical care, clothing for mother and child, housing, transportation, furniture, financial counseling and assistance, and educational programs in nutrition, parenting, natural childbirth, breast-feeding, and other parent/child-oriented seminars. In addition, Womankind makes available professional and paraprofessional counselors specially trained in the sensitive areas of adoption and single parenthood through agreements with local accredited social services agencies. In 1981, seven staff members and 170 volunteers at two offices provided services to 7,183 clients. As an agency with the primary purpose of providing long term, positive assistance to persons in crisis due to an untimely pregnancy, Womankind is precisely the sort of agency about which pregnant women contemplating abortion are to be informed under Akron, Oh. Codified Ordinances §1870.06 (B)(7).

The trained professionals and paraprofessionals who staff Womankind have come in contact with thousands of women considering a choice between abortion and childbirth. Their experience gives them considerable insight

into the nature of the difficult dilemma these women face, and into the need these women have for material information about abortion and its alternatives in order freely to make a decision which is truly their own.

SUMMARY OF ARGUMENT

The Sixth Circuit struck down abortion informed consent provisions of the Akron, Ohio Ordinances because it held they "impinge[d] on the medical judgment of the attending physician [by requiring] the doctor to make certain disclosures in all cases, regardless of his professional judgment as to the desirability of doing so." *Akron Center for Reproductive Health* v. *City of Akron*, 651 F.2d 1198, 1207 (6th Cir. 1981). Similar grounds have been given by most of the other lower federal courts that have invalidated abortion related informed consent legislation.

This position is quite similar to the "physician paternalism" approach to informed consent requirements in medical malpractice litigation, an approach taken by 23 States and Puerto Rico. Under that approach, which is the original rule, the standard of disclosure is set by the practice of physicians in the locality.

The Sixth Circuit's position is at odds, however, with the newer "patient autonomy" approach taken by 10 States (including Ohio) and the District of Columbia, under which the standard of disclosure is not decided by physicians but imposed by the law. Under the "patient autonomy" approach, the physician is required to disclose whatever an average reasonable patient would consider material to the decision to undergo or refuse treatment, including the nature and purpose of the procedure, its risks, and available alternatives. Since 13 States take intermediate hybrid approaches, the position of the Sixth Circuit in asserting absolutely untrammeled discre-

tion in the physician about what to disclose is inconsistent with the malpractice informed consent disclosure standards of 23 States and the District of Columbia.

In effect, the Sixth Circuit and the other courts that have invalidated abortion related informed consent legislation have imposed upon the States what has been the view at one end of the spectrum of a controversy over informed consent standards of disclosure. At least in the context of abortion, they have frozen in constitutional concrete what has been hotly debated by commentators, courts and legislatures and hitherto open for state by state judgment and experimentation.

The Akron Ordinance applies the basic "patient autonomy" approach employed by Ohio to the particular circumstances of abortion. All of the categories in which it requires disclosure meet the basic standard that the information be material to the decision. It is disingenuous to argue, as some lower courts have, that information about the fetus is "medically irrelevant" to a woman's decision, since the essence of the procedure is elimination of the fetus. Withholding such information, ostensibly to spare pregnant women's sensitivities, makes a paternalistic mockery of the "freedom of choice" right, and skews the basis for her decision.

Although the laws of some "patient autonomy" jurisdictions, unlike the Akron Ordinance, have a "therapeutic exception" to the duty of disclosure when the physician thinks disclosure will harm the patient, others, including Ohio, do not. Furthermore, scholarly commentators have attacked the "therapeutic exception" as destructive of the disclosure rule, more harmful than good in the long run, and unnecessary for competent patients. Thus, the Akron Ordinance is well within the bounds of the "patient autonomy" approach to informed consent.

Legislatures have particularly appropriate grounds for applying a "patient autonomy" rather than a "physician paternalism" approach in the area of abortion. Most abortions are not performed in the context of the traditional physician-patient relationship. Rather, they take place at abortion clinics in many of which the patient does not even meet a physician until she is on the operating table. "Counseling," when it exists, is done by nonmedical personnel, sometimes only in groups. This atmosphere does not allow for the individualized physician judgment about disclosure presupposed by the benevolent assumptions underlying the "physician paternalism" approach. Furthermore, information publicized as a result of the 1978 *Chicago Sun-Times* undercover investigation of a number of high-volume abortion clinics shows that "counseling" is sometimes designed to "sell" abortions rather than to foster the best interests of the patient. It documents that a significant number of abortion clinic doctors pay scant attention to patient care in their rush to perform as many abortions as possible to increase their personal profits.

Both the socioeconomic context in which abortion is frequently performed and the special "freedom of choice" nature of the abortion right make especially defensible a legislative choice of the "patient autonomy" over the "physician paternalism" approach to abortion informed consent. Whatever rules this Court may announce to govern informed consent statutes, the Constitution should not be interpreted to rob the States of the flexibility to prefer a "patient autonomy" approach to abortion.

ARGUMENT

I.

CONSIDERATION OF THE CONTROVERSY BETWEEN THE "PHYSICIAN PATERNALISM" AND THE "PATIENT AUTONOMY" APPROACHES TO GENERAL INFORMED CONSENT DOCTRINE IS CRITICAL IN DECIDING THE CONSTITUTIONALITY OF THE "INFORMED CONSENT" PROVISIONS OF THE AKRON ORDINANCE.

The Sixth Circuit Court of Appeals invalidated every provision of the Akron, Ohio Codified Ordinances requiring disclosure of information to a woman before she consents to an abortion. It did so because that court deemed it to be unconstitutional for any legislature to "impinge on the medical judgment of the attending physician [by requiring] the doctor to make certain disclosures in all cases, regardless of his own professional judgment as to the desirability of doing so." *Akron*, 651 F.2d at 1207. Many other courts that have held abortion related informed consent statutes unconstitutional have also grounded such rulings in the proposition that no legislature may interfere with the untrammeled discretion of a physician to withhold information from patients prior to an abortion. *See, e.g., Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft*, 655 F.2d 848, 867 (8th Cir. 1981); *Charles* v. *Carey*, 627 F.2d 772, 784 (7th Cir. 1980); *Leigh* v. *Olson*, 497 F.Supp. 1340, 1345 (D.N.D. 1980).

Although no lower court dealing with abortion related informed consent legislation has taken note of it, courts and scholarly commentators are currently engaged in a controversy over what ought to be the standard of disclosure for informed consent to medical treatment of any kind. This debate, which is being conducted without specific reference to abortion, concerns two competing perspectives.

One perspective, which emphasizes physician discretion and judgment, may be called the "physician paternalism" approach. Its proponents say the standard of disclosure ought to be that practiced by physicians in the locality. This approach, like that taken by the Sixth Circuit in this case, assumes that doctors generally know what is best for their patients, and gives doctors, as a group, great leeway to circumscribe the breadth and scope of the information to be disclosed to or withheld from the patient.

The other perspective, which emphasizes patient knowledge and decision, may be called the "patient autonomy" approach. Its proponents say the standard of disclosure ought to be what an average, reasonable patient would consider material to the decision, regardless of what physician practice may be. This approach assumes that competent adults should be enabled to determine for themselves what is done with their bodies, and places the premium on patient freedom of choice.

Ohio case law on informed consent to medical treatment in general has adopted the "patient autonomy" approach. *Congrove* v. *Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765, 771 (Comm. Pleas 1973). See Section III of this brief. The City Council of Akron chose to apply this approach to abortion by adopting an ordinance specifying particular required disclosures. See Section IV of this brief. The municipal legislature chose not to defer to the abortion-performing physician's view of what is best and allow him or her to control the flow of information to the patient, as does the "physician paternalism" approach; rather, it proceeded on the assumption that abortion is an especially personal decision, to be made by the woman herself, and sought to assure her of access to the information material to that decision, thus employing the rationale behind the "patient autonomy" approach.

Without any discussion of the arguments which have been advanced for and against each approach, or of the

relation of constitutional provisions to those arguments, the Sixth Circuit and other courts, in striking abortion related informed consent laws, have in effect held that in the context of abortion the Constitution imposes on the States the "physician paternalism" option and forbids to them the "patient autonomy" option.

In the belief that no final ruling on the application of the Constitution to informed consent requirements for abortion should be made without at least some consideration of the nature of informed consent requirements for medical treatment in general, your *amicus* offers this brief for the limited purpose of discussing the debate over the two competing approaches to informed consent disclosure standards and the relevance of that debate to the validity of legislative judgments about what standard best achieves effective freedom of choice for women deciding whether to undergo abortion.

This brief addresses what should be a central issue in this case: whether, in light of the considerable controversy over the respective wisdom of the "physician paternalism" and "patient autonomy" approaches, the Court should adopt a rule that constitutionally freezes the "physician paternalism" approach as the only allowable model for abortion related informed consent legislation, or whether, "when an issue involves policy choices as sensitive as those implicated [here] . . . , the appropriate forum for their resolution in a democracy is the legislature." *Maher* v. *Roe*, 432 U.S. 464, 479 (1977).

II.

MEDICAL TREATMENT REQUIRES THE CONSENT OF THE PATIENT, AND THE UNIVERSAL MODERN RULE IS THAT THE CONSENT MUST BE INFORMED.

Under Anglo-American law, it is axiomatic that a physician must first obtain the patient's consent before undertaking any non-emergency treatment. As Justice Cardozo

stated in *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914):

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.

As the consent doctrine evolved, it became necessary under the law for the physician not only to obtain permission to proceed, but also to make a reasonable disclosure to the patient of the nature and probable consequences of the proposed treatment. *See Salgo* v. *Stanford University Bd. of Trustees*, 154 Cal. App.2d 560, 317 P.2d 170 (Ct. App. 1957) (landmark case introducing the principle). "Numerous courts throughout the 1960's looked beyond the fact of the patient's consent to question the quality of the physician's disclosure underlying the consent." A Rosoff, *Informed Consent* 4 (1981). Some version of informed consent requirement is now in effect in all but two of the United States. *See* Table of Current Positions on the Approach to Informed Consent by State, this brief at 11; App. 6n.42 (S.C.); App. 6n.43 (S.D.).

III.

THE OLDER "PHYSICIAN PATERNALISM" APPROACH HAS BEEN REPLACED BY THE NEWER "PATIENT AUTONOMY" APPROACH IN OHIO AND A SUBSTANTIAL NUMBER OF OTHER STATES.

When informed consent doctrine first came to be applied in the late 1950s and early 1960s, it was initially analyzed in the manner of traditional medical malpractice tort negligence. Like the duty of care by which deviations amounting to negligence are measured, the duty of disclosure by which deviations amounting to denial of informed consent were to be measured was set as "those disclosures which a reasonable medical practitioner would make under the same

or similar circumstances." *Natanson* v. *Kline*, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960). This approach came to mean that a physician need only disclose those facts which the average, reasonable practitioner, of the same speciality and geographic location, would have revealed under similar circumstances. Victor, *Informed Consent*, 1981 Medical Trial Tech. 138, 146. *See, e.g., Woolley* v. *Henderson*, 418 A.2d 1123, 1128-32 (Me. 1980).

Courts first began to move away from this approach in dealing with elective surgery—a category into which most abortions fall. For example, in *Scott* v. *Wilson*, 396 S.W. 2d 532 (Tex. Civ. App. 1965) *aff'd sub. nom Wilson* v. *Scott*, 412 S.W.2d 299 (Tex. 1967), the court held that when a patient is considering an elective operation, a physician has the duty to make a full disclosure of the nature of the operation, the processes contemplated, the dangers of the operation and possible alternatives to the treatment.

The full introduction of the "patient autonomy" approach into case law came in *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), which remains the leading case. The D.C. Circuit concluded that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 780. It based its decision on the premise that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests lie," and that the duty to disclose information important for that determination is not "dependent upon the existence and nonperformance of a relevant professional tradition." *Id.* at 777, 779.

Instead of usual professional practice, therefore, the court concluded that

> the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effective-

> ly exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision.

Id. at 782-83.

The *Canterbury* v. *Spence* "patient autonomy" approach came to be followed by a substantial minority of jurisdictions. Adopting the position, a Maryland court summarized the trend:

> In recent years . . . an ever-expanding number of courts have declined to apply a professional standard of care in informed consent cases, employing instead a general or lay standard of reasonableness set by law and independent of medical custom. These decisions recognize that protection of the patient's fundamental right of physical self-determination—the very cornerstone of the informed consent doctrine—mandates that the scope of a physician's duty to disclose . . . be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.

Sard v. *Hardy*, 281 Md. 432, 442, 379 A.2d 1014, 1021 (Ct. App. 1977). *See also* Victor, *supra* p. 9, at 148; Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 Duq. L. Rev. 309, 312 (1976). The accompanying table summarizes the 1982 position on standards of disclosure of D.C., Puerto Rico, and the 50 states. 24, or half of the jurisdictions with positions, adopt an approach differing from the pure "physician paternalism" model which the Sixth Circuit held to be the only approach the Constitution accepts when applied to abortion.

TABLE OF CURRENT POSITIONS ON THE APPROACH TO INFORMED CONSENT BY STATE*

State	No Law	Patient Autonomy	Physician Paternalism	Hybrid
Alabama[1]			X	
Alaska[2]				X
Arizona[3]			X	
Arkansas[4]			X	
California[5]				X
Colorado[6]			X	
Connecticut[7]	X			
Delaware[8]			X	
District of Columbia[9]		X		
Florida[10]				X
Georgia[11]			X	
Hawaii[12]			X	
Idaho[13]				X
Illinois[14]			X	
Indiana[15]				X
Iowa[16]				X
Kansas[17]			X	
Kentucky[18]				X
Louisiana[19]		X		
Maine[20]			X	
Maryland[21]		X		
Massachusetts[22]				X
Michigan[23]			X	
Minnesota[24]		X		
Mississippi[25]			X	
Missouri[26]			X	
Montana[27]			X	
Nebraska[28]			X	
Nevada[29]				X
New Hampshire[30]			X	
New Jersey[31]			X	
New Mexico[32]		X		
New York[33]			X	
North Carolina[34]				X
North Dakota[35]			X	
Ohio[36]		X		
Oklahoma[37]				X
Oregon[38]		X		
Pennsylvania[39]		X		
Puerto Rico[40]			X	
Rhode Island[41]		X		
South Carolina[42]	X			
South Dakota[43]	X			
Tennessee[44]			X	
Texas[45]				X
Utah[46]			X	
Vermont[47]				X
Virginia[48]			X	
Washington[49]		X		
West Virginia[50]	X			
Wisconsin[51]		X		
Wyoming[52]			X	
TOTAL	4	11	24	13

* The sources for this summary are given state by state in the Appendix.

The only Ohio court to face the issue squarely has adopted the patient autonomy rule, relying on *Canterbury*.* "The duty to disclose serious risks should not be based upon the doctor's practices but upon the patient's need for full disclosure of serious risks and the feasibility of alternatives in order for the patient to make an intelligent and informed choice." *Congrove* v. *Holmes*, 308 N.E.2d at 771 (Comm. Pleas 1973). The Ohio informed consent statute applicable to medical treatment generally provides that in order for written consent to be presumed valid, it must set "forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, [set] forth the name of the physicians who shall perform the intended surgical procedures." Oh. Rev. Code Ann. § 2317.54 (A) (Baldwin Supp. 1981).

The newer "patient autonomy" approach, therefore, is seen to be an approach accepted and advocated by a substantial minority of States for reasons closely related to the essential basis of informed consent doctrine. This understanding counsels against pre-empting legislative choice through the establishment of a constitutional rule compelling "physician paternalism."

IV.

THE AKRON ORDINANCE APPLIES THE "PATIENT AUTONOMY" APPROACH TO ABORTION.

The Akron Ordinance provides for disclosure concerning the woman's pregnancy, abortion risks, alternatives to

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* In *Bruni* v. *Tatsumi*, 46 Oh. St. 2d 127, 136, 346 N.E.2d 673, 680 (1976), the Ohio Supreme Court, in dealing with other aspects of informed consent doctrine, which it described as "not particularly well-developed in Ohio cases," relied primarily upon *Canterbury*. However, the court did not deal with the issue of the "patient autonomy" vs. the "physician paternalism" standards of disclosure.

abortion, and the fetus. It was logical for the municipal legislature to consider all of these categories to be material to the decision whether or not to undergo the procedure, and since materiality to the decision is the standard for disclosure employed by the courts that have adopted the "patient autonomy" approach, disclosure with regard to these categories lies fully within the bounds of informed consent doctrine.

> Over the 20-odd years since the term *informed consent* came into usage in the medicolegal context, courts have been developing, on a case-by-case basis, a list of items requiring disclosure. Stated in simple, generic terms, the list includes:
>
> * diagnosis (i.e., the patient's condition or problem)
> * nature and purpose of the proposed treatment
> * risks and consequences of the proposed treatment
> * probability that the proposed treatment will be successful
> * feasible treatment alternatives
> * prognosis if the proposed treatment is not given.

Rosoff, *supra* p. 8, at 41 (emphasis in original).

The specific requirements of the Akron Ordinance fit within these categories. The disclosure provided by §§1870.06(B)(1) and (2) concerning the patient's pregnant condition and the stage of her pregnancy is of diagnostic information. The disclosure provided by §1870.06(B)(7) concerning the agencies and services available to assist her during pregnancy and after childbirth if she does not choose abortion is of information concerning treatment alternatives. The disclosure provided by §1870.06(B)(5) concerning the possible complications of abortion is of information in a classic informed consent category: risks of the proposed treatment. So long as the "patient autonomy" approach is accepted as a constitutionally available alternative to the "physician paternalism" approach for abortion related informed consent legislation, objection can hardly be made to requiring specific disclosures in these categories.

It has been suggested, however, that disclosure concerning the existence and characteristics of the fetus, such as that provided by Akron Oh. Codified Ordinances §§1870.06 (B)(3) and (4), "is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement." *Planned Parenthood League of Massachusetts* v. *Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981). This perception misconceives both the nature of the standard of disclosure in informed consent doctrine—at least under the "patient autonomy" approach—and the meaning of "medically relevant" in the context of abortion as that concept has been delineated by this Court.

"[T]he very basis of the informed consent theory [is] the patient's right to be the final judge to do with his body as he wills." *Wilkinson* v. *Vesey*, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972). Central to this position is the view that the "decision about what is or is not relevant information upon which a patient can base an informed consent is a human judgment, not a determination requiring medical expertise." Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 Yale L.J. 1533 (1970). *Accord, Wilkinson*, 110 R.I. at 625, 295 A.2d at 688. In the "patient autonomy" view, therefore, the nature of the information deemed material to the patient's decision is not inherently limited to a description only of physical health risks associated with the procedure; rather, the question of materiality is, as a Washington court phrased it, "Would the patient as a human being consider this item in choosing his or her course of treatment?" *Miller* v. *Kennedy*, 11 Wash. App. 272, 282-283, 522 P.2d 852, 860 (Ct. App. 1974), *aff'd* 85 Wash.2d 151, 530 P.2d 334 (1975).

Thus, Ohio's informed consent statute applicable to all forms of medical treatment provides for information not

only about the "reasonably known risks," but also about "the nature and purpose of the procedure." Oh. Rev. Code Ann. § 2317.54 (A) (Baldwin Supp. 1981). The Akron Ordinance applies this perspective specifically to abortion. It provides for information about the existence and development of the fetus whom it is the nature and purpose of the procedure to eliminate.

It is simply disingenuous to argue that information about the fetus is irrelevant to a choice about abortion, and that the only things "the patient as a human being [would] consider" in making a reflected choice whether to undergo it are physical health risks. As this Court noted in *Roe* v. *Wade*, 410 U.S. 113, 116 (1973), "One's philosophy, one's experiences, one's exposure to the raw edges of human existence, . . . one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion." That network of values revolves around the attitude one takes toward the fetus's status and prospects as weighed together with the needs and plans of the pregnant woman and perhaps her family. If, as Laurence Tribe has suggested, "*Roe* v. *Wade* represents less a decision in favor of abortion than a decision in favor of leaving the matter, however it might come out in particular cases, to women . . . ," L. Tribe, American Constitutional Law 933 (1978), then it cannot properly be said that the whole tangle of ethical and human issues inherently associated with abortion are to be deemed irrelevant to women's decisionmaking. Those issues are inextricably bound up with the existence and nature of the fetus.

The applicability of the "patient autonomy" informed consent rationale is not diminished because information about the fetus has no precise analogue in information required to be disclosed about other medical procedures. "The simple answer to the argument that similar require-

ments are not imposed for other medical procedures is that such procedures do not involve the termination of a potential human life." *Maher* v. *Roe,* 432 U.S. at 480. The essential point is that the rationale for the disclosure of fetal information is the same as that for the disclosure of information associated with medical treatment other than abortion: in the "patient autonomy" view, disclosure should be made of "what the patient would consider important to [her] decision." *Canterbury* v. *Spence,* 464 F. 2d at 783. It is logical for the legislature to conclude that information about the fetus meets that criterion.

There is another reason why the First Circuit was wrong to consider fetal information "medically irrelevant." Its notion of the scope of medical relevance is mechanistically narrow in a manner at odds with this Court's delineation of that concept in the context of abortion. "[M]edical judgment," the Court held, "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health." *Doe* v. *Bolton,* 410 U.S. 179, 192 (1973). This sense of the medically relevant is certainly broader than merely physical complications; it argues against the exclusion of fetal information from the realm of the "medical."

In sum, abortion related informed consent legislation like the Akron Ordinance is rooted in the philosophy that underlies the "patient autonomy" approach to informed consent used by a respectable minority of the States: "The patient has the right to chart [her] own destiny, and the doctor must supply the patient with the material facts the patient will need in order to intelligently chart that destiny with dignity." *Miller* v. *Kennedy,* 11 Wash. App. at 282, 522 P.2d at 860. The requirement to disclose information about the woman's pregnancy, abortion risks,

alternatives to abortion, and the fetus is medically relevant and fits appropriately with "patient autonomy" informed consent doctrine.

V.

FROM A "PATIENT AUTONOMY" PERSPECTIVE, THERE IS AMPLE PRECEDENT AND REASON FOR PROVIDING NO "THERAPEUTIC EXCEPTION" IN THE AKRON ORDINANCE.

The Akron Ordinance requires disclosure in all non-emergency instances. It thus parts company with some "patient autonomy" jurisdictions which hold that a physician has a limited privilege not to disclose information to a patient for "therapeutic" reasons, an exception to the general duty of disclosure which is not recognized by other states and which has been subjected to considerable scholarly attack. The exception, where it is recognized, is meant to deal with occasions when disclosure would risk making a patient "so ill or emotionally distraught . . . as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient." *Canterbury* v. *Spence*, 464 F.2d at 785. The Canterbury court itself warned, however, that the therapeutic exception

> must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity even for the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

Id.

The court concluded that the privilege to withhold disclosure should operate only when the physician reasonably

forsees that the patient's reaction will be "menacing." *Id.** Indeed, a number of states which employ or have elements of the "patient autonomy" approach have failed to recognize a "therapeutic exception." Notably, Ohio is among them. (The others are Florida, Kentucky, Nevada and Pennsylvania.) Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. Pitt. L. Rev. 407, 457 (1980); *Dunham* v. *Wright*, 423 F.2d 940, 944-45 (3rd Cir. 1970) (construing Pennsylvania law).

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* The heart of the argument given by "patient autonomy" jurisdictions for rejecting "physician paternalism" is that "[u]nlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected." *Cobbs* v. *Grant*, 8 Cal.3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972). It is not surprising, therefore, that even in States allowing the therapeutic exception a number of courts have openly recognized the dangers it poses and endeavored to construe it extremely narrowly. In *Kinikin* v. *Heupel*, 305 N.W.2d 589 (Minn. 1981), for example, the Minnesota Supreme Court declared that a doctor cannot invoke the therapeutic privilege merely to avoid aggravating a patient's emotional trauma when sound medical practice demands that risks be disclosed. The court asserted that the greater a patient's fears, no matter how peculiar or unfounded they may be, the greater is the physician's duty to discuss the risks of treatment. "In all situations, it is to the advantage of both the patient and his physician that the latter not presume too much upon the apparent experience or expertise of the former." *Id.* at 595. Similarly, in denying a claim that information relating to ulcer surgery was properly withheld under the therapeutic privilege, the California Supreme Court noted that the role of the doctor, as an expert, is only to know and reveal the risks inherent in medical procedures. "The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone." *Cobbs* v. *Grant*, 8 Cal.3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

Three grounds are given in the scholarly commentary for rejection of the therapeutic exception, grounds that provide a supportable basis for the decision of the Akron City Council not to include such an exception in the Akron Ordinance: 1) as *Canterbury* concedes, the exception poses grave danger of vitiating the rule; 2) the harm that may come from disclosures the therapeutic exception is intended to prevent is minimal and in any case less than the harm likely to come from preventing these disclosures, and 3) the sort of disclosures most likely to be harmful are adequately prevented by the incompetency exception without need for a therapeutic exception.*

There is strong academic criticism of the therapeutic exception. Professor Alan Meisel, who teaches psychiatry as well as law, believes "(t)he danger that the therapeutic privilege poses to self-determination in medical decisionmaking is so great that we should seriously consider its abolition." Meisel, *The "Exceptions" to the Informed Consent Doctrine,* 1979 Wisc. L. Rev. 413, 467. Meisel warns that even when the therapeutic exception is narrowly circumscribed, the manner in which it is applied can still undermine patient autonomy. The power the law gives to physicians to determine how and whether the exception applies creates "an incentive for the physician to invoke an exception in order to provide treatment to a patient whom he believes would refuse it." *Id.* at 476. Coupled with "the physician's authority and control over

* "A patient whose emotional state is so fragile that risk-disclosure might seriously harm him or prevent him from participating rationally in decisonmaking might be considered incompetent. . . . If there is any room at all for the [therapeutic] privilege, it must be framed in terms of interference with the patient's decisionmaking capabilities, in which case the incompetency exception might serve as well." Meisel, *The "Exceptions" to the Informed Consent Doctrine,* 1979 Wisc. L. Rev. 413, 467.

relevant information, and traditionally deferential patient attitudes towards physicians," this power to invoke the therapeutic exception successfully tips the balance between individualism and the health profession in favor of physician paternalism. *Id.* at 471. As another commentator noted, "Available evidence indicates that the physician's decisions to withhold information are based on hearsay rather than on actual experience with the effects of full disclosure and that the physician's own emotional reluctance to confront the patient with stark diagnoses and risks often prevents disclosure." Note, *Restructuring Informed Consent, supra* p. 14.

Although patients are usually upset by the disclosure of serious risks of medical treatment, Meisel writes, it is not clear that being upset necessarily interferes with one's ability to engage in rational decisionmaking. Meisel, *supra* p. 19, at 461. Professor Simpson of Northwestern University Law School concurs with Meisel, arguing that the traditional pessimism of courts over the ability of patients to make rational decisions about their medical treatment is based on "myth" and conjecture. Simpson, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 N.U. L. Rev. 172, 178 (1981). "It appears that the possibility of adverse effects arising from disclosure has been overstated," asserts Simpson. Studies show that the large majority of patients do not refuse treatment after being informed about "relatively risky medical procedures," that they withstand surgery better than uninformed patients and that, on the average, informed patients "suffer equal or lower levels of anxiety" than patients who are not informed. *Id.* at 180.

In the abortion context, the psychological harm to the patient assertedly associated with disclosure of information about the fetus (*see Planned Parenthood League of Massa-*

chusetts v. *Bellotti*, 641 F.2d at 1021; *Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft*, 655 F.2d at 868; *Charles* v. *Carey*, 627 F.2d at 784) may be experienced far more severely after the procedure has been irrevocably performed if the patient later learns about the information withheld from her. For example, *Good Housekeeping* interviewed a woman who had had an abortion in college while thinking that the fetus was just a "clump of cells." "A year later at a friend's house someone was passing around pictures of fetuses in various stages of development. When I saw that a three-month-old 'clump of cells' had fingers and toes and was a tiny, perfectly-formed baby, I became really hysterical." Rockmore, *Are You Sorry You Had an Abortion?* Good Housekeeping, July 1977, at 120-21 (*quoting* Julie Engel); *see also id.* at 162-63 (*quoting* Georgia Denk). Common sense suggests that the very women who are most likely to be upset by disclosures before the abortion, and thus those most likely to be candidates for the therapeutic exception, are the ones most likely to experience psychological complications after the abortion upon learning the information withheld. Furthermore, they are precisely the women whose choice would most likely be different if fully informed, and thus those most likely to be deprived of a truly autonomous choice by the paternalistic decision not to disclose.

Surely it should be within the legislature's discretion to decide whether, in a particular context, the adoption of a therapeutic exception enhances or harms informed consent legislation based on the "patient autonomy" approach. The decision of the Akron City Council not to include such an exception in the Akron Ordinance must be regarded as embodying a position grounded in precedent, properly responsive to the particular circumstances of abortion, and supported by respectable opinion in the scholarly debate.

VI.

WELL-PUBLICIZED ABUSES BY ABORTION CLINIC PHYSICIANS AND COUNSELORS MAKE IT PARTICULARLY APPROPRIATE FOR LEGISLATURES TO PREFER THE "PATIENT AUTONOMY" TO THE "PHYSICIAN PATERNALISM" APPROACH IN APPLYING THE INFORMED CONSENT DOCTRINE TO ABORTIONS.

Whatever may be the merits of the debate over "physician paternalism" and "patient autonomy" as applied to medical treatment in general, there is substantial evidence to justify a legislative conclusion that in a significant number of abortions there is a lack of meaningful contact and a fundamental conflict of interest between the physician and the patient. In many cases the physician-patient relationship is so poor that it vitiates the benevolent assumptions underlying the "physician paternalism" approach.

> The evidence presented at trial showed that the decision to terminate a pregnancy was made not by the woman in conjunction with her physician, but by the woman and lay employees of the abortion clinic, the income of which is dependent upon the woman's choosing to have an abortion. The testimony disclosed that the doctors at Akron Center's clinic did little, if any, counseling before seeing the patient in the procedure room. Akron's ordinance simply takes into account these realities of the "physician-patient" relationship at an abortion clinic.

Akron, 651 F.2d at 1217 (Kennedy, J., concurring in part and dissenting in part).

In a decision affirmed in relevant part by this Court, a three-judge court pointed out the essential difference between the circumstances surrounding many abortions and the doctor-patient interaction typical of other medical treatment.

> Abortions are frequently obtained in a specialized clinic or hospital department where a woman is removed from familiar medical surroundings. Most frequently the abortion is not done by a woman's regular doctor. The procedures, perhaps routine for those performing them, will probably be totally unlike any other theretofore undergone by the patient. In addition, as the record in this case indicates, the woman may well be experiencing considerable emotional anxiety.
>
> Generally, the abortion decision is somewhat hurriedly arrived at and executed. It, in many cases, may be attended by a retiscence [sic] that works to close off ordinary avenues of information to the patient either from friends or from family members.
>
> The state under such circumstances might understandably wish to be certain that each woman be given the facts regarding her condition, her options, the abortion procedure to be performed, and the possible future consequences of the choice she makes.

Planned Parenthood Association v. *Fitzpatrick*, 401 F. Supp. 554, 587 (E.D. Penn. 1975), *aff'd in relevant part*, 428 U.S. 901 (1976). In 1980, 75% of all abortions were performed in clinics or offices in which 1000 or more abortions were performed annually. Henshaw, Forrest, Sullivan & Tietze, *Abortion Services In The United States, 1979 & 1980*, 14 Fam. Plan. Perspectives 1, 12, Table 6 (1982).

What sort of doctors must many of the women seeking abortion turn to? On November 12, 1978, the *Chicago Sun-Times* began reporting the results of a five month undercover investigation of Chicago abortion clinics it had conducted in cooperation with the Better Government Association. "Reporters and researchers worked in six clinics where more than half of the 60,000 abortions in Illinois clinics were performed last year, according to state records and BGA [Better Government Association] estimates." Zekman & Warrick, *The Abortion Profiteers: Making a killing in Michigan Av. Clinics*, Chicago Sunday

Sun-Times, Nov. 12, 1978, at 4, col. 1. They found extremely questionable attitudes and practices in four of the clinics, as well as in two counseling and referral agencies. Excerpts from the exposé demonstrate that a legislature might logically conclude that the decisions made by some abortion clinics concerning what information to disclose to their patients are motivated by a desire for profits rather than by a good faith judgment based on their patients' best interests.

> At the Chicago Loop Mediclinic, . . . an administrator told women answering phones: "We have to corral the patients. . . . Our fiscal year ends in September, so go the extra mile."
>
> For their extra efforts, clinic workers get $5 cash bonuses for each abortion they sell over the phone.
>
> At a referral service that operates three hot lines, undercover BGA investigator Julia Rockler was admonished for not selling hard enough while working as an employee there.

Id. at 4, col. 3.

> "We are in the business of selling abortions," McCullough scolded. "When you are talking to these people, it's important to use the positive approach. It's not 'Do you want a termination?' but 'When do you want a termination?' Put the question to them as a sure sale. Limit their choices."

Zekman & Warrick, *Soft voices, hard sells—twin swindles,* Chicago Sun-Times, Nov. 17, 1978, at 4, col. 3.

> "Counseling?" said a former hot-line worker. "There was none. What we were doing there is selling abortions. We got no training except in what not to say. How not to use words like 'fetus' or 'kill' that might scare the customers away. Don't mention complications."
>
> Within minutes of being hired at McCullough's hot line, Rockler was told to start "counseling." When

she asked for help in explaining the abortion procedure to a patient, she was told to sum it up like this:

"A tube about the size of a pencil is inserted into the uterus and the vacuum aspirator is turned on and removes all the liquid. There is no scraping or cutting. Now do you have any questions?"

If there were questions, counselors were left to their own devices to answer them. "But McCullough's policy," said a former worker, "was to tell people as little as possible."

At both hot lines, women intentionally are told what will sell them on abortion. When patients complained of the cost of abortions at the Sanders hot line, Trossman heard counselors remind callers of the cost of not having an abortion.

"Having a baby is a $410,000 question," a hot line caller was told. "Do you have that kind of money to raise a kid?"

Id. at 5, col. 2.

Often, as the series documented, the abortion-performing physician, far from counseling the patient, has no contact with her until she is in the procedure room.

A woman who had an abortion one early August morning recalls lying on the operating table waiting for her doctor—30-year-old Dr. Pankaj Thaker—to get to her. "I could swear there was only one doctor and he just went down the line giving abortions," said the woman.

. . .

"He didn't say a word. He came in and did it and walked out in three minutes. Then he started down the hall again. . ."

Zekman & Warrick, *The Abortion lottery: Women take chances with 'tryout' doctors,* Chicago Sun-Times, Nov. 14, 1978, at 4, cols. 1, 4.

In this hectic assembly-line, profit-hungry atmosphere, there is little time for or interest in genuine counseling by the staff, let alone the doctor.

> At the Biogenetics clinic, BGA investigator Michelle Young was ordered by her supervisor to stop counseling a distraught patient and get back to the reception desk.
>
> "We don't have time for [counseling]," the supervisor said. "We're much too busy."
>
> When staff members do have time to talk to patients, they are under orders not to say anything to scare the women away.
>
> "Don't tell them it hurts" our undercover counselor was told. "Don't answer too many questions because the patient gets too nervous, and the next thing you know they'll be out the door."

Zekman & Warrick, *Dr. Ming Kow Hah: physician of pain*, Chicago Sun-Times, Nov. 15, 1978, at 4, col. 4.

In the *Akron* case, a physician employed by one of the plaintiff clinics testified that the need for disclosure is limited because he assumes that an abortion clinic patient has "already made her own decisions. . . . When you go to a bar, you go there to drink." Tr. VII, 33-34. But the *Sun-Times* investigation provided evidence from which a legislature could properly conclude this is not always the case.

> Not all women who go to abortion clinics are sure they want abortions. Some arrive confused and frightened, not at all sure they want to be there.
>
> Some have been dragged into clinics by relatives; others pressured into abortion by husbands or boy friends.
>
> . . .
>
> [A] Biogenetics patient told The Sun-Times she might not have gone through with her abortion had someone taken the time to counsel her.

> "I wasn't counseled at all," she said. "The nurse just took my name down and filled out the application. She gave a quick explanation of the procedure, but that's not counseling. I wasn't sure I wanted an abortion. I really wanted to talk to somebody about it."

Zekman & Warrick, *Counseling the patient: Buy this abortion,* Chicago Sun-Times Nov. 24, 1978, at 5, cols. 1, 4.

In *Canterbury* v. *Spence,* 464 F.2d at 784, the District of Columbia Circuit said, "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." Surely the abuses documented make it constitutionally appropriate for a legislature, if it chooses, to enact laws establishing informed consent specifications for physicians engaged in abortion practice which depart from the "physician paternalism" assumption that doctors know best what degree of disclosure is right for their patients and can be trusted to act in their best interests.

VII.

THE CONSTITUTION SHOULD NOT BE INTERPRETED TO PRECLUDE RELIANCE ON THE "PATIENT AUTONOMY" APPROACH WHEN STATES ACT TO PROTECT THE RIGHT OF WOMEN TO GIVE INFORMED CONSENT TO ABORTION.

The constitutional liberty which encompasses abortion is "the freedom of a woman to decide whether to terminate a pregnancy." *Harris* v. *McRae,* 448 U.S. 297, 312 (1980). This "freedom of choice" (*id.*) includes "at least an equal right to choose to carry her fetus to term as to choose to abort it." *Maher* v. *Roe,* 432 U.S. at 472 n.7. Surely the legislature has a legitimate and compelling interest in

protecting the exercise of this fundamental constitutional right.

On the other hand, physicians have no constitutional right to a "physician paternalism" standard of disclosure; their protection from state interference is purely derivative from "the right of a pregnant woman to decide whether or not to bear a child." *Whalen* v. *Roe*, 429 U.S. 589, 604-605n.33 (1977). Physicians have no constitutional entitlement, therefore, to ensure that only a "physician paternalism" approach to informed consent is applied to abortion, while the legislature has the strongest constitutional warrant for applying the "patient autonomy" approach.

The Akron City Council has not "singled out" abortion for the application of the "patient autonomy" approach; the informed consent law of Ohio employs the "patient autonomy" approach, with no therapeutic exception, in dealing with all medical procedures. *See* this brief, *supra* at 12, 18. The Council has simply applied the general Ohio rule to the particular circumstances of abortion. A statute as precise as the Akron Ordinance in what it requires to be disclosed is not without precedent in the field of informed consent legislation. Some informed consent laws establish what physicians must disclose about particular operations with a similar degree of detail: Tex. Rev. Civ. Stat. Ann. art. 4590 § 6.05 (Vernon Supp. 1982), as implemented by 3 Tex. Reg. 4293 (1978), names, for example, five specific potential consequences of abdominal and vaginal hysterectomies to be communicated to the patient.

In light of the abuses related in Section V of this brief, however, even a jurisdiction that generally adheres to the "physician paternalism" approach, or accepts the therapeutic exception to the "patient autonomy" approach,

could properly decide that the special circumstances created by the socioeconomic context in which abortions are frequently performed suggest a need for the application of a "patient autonomy" approach, without any therapeutic exception, to protect women considering whether to terminate their pregnancies.

This Court pointed out in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 67 (1976), that when a consent requirement "for any surgery" would be constitutional, there is "no constitutional defect in requiring it only for some types of surgery as . . . for abortions." If the "patient autonomy" approach is constitutional as applied to medical treatment in general, it should be equally constitutional as applied to abortion whether the jurisdiction generally applies it to all medical treatment, as Ohio does, or particularly to abortion because of the special circumstances surrounding that procedure.

CONCLUSION

Justice Holmes wrote in his famous "now vindicated dissent in *Lochner* v. *New York*, 198 U.S. 45, 76 (1905)", *Roe* v. *Wade*, 410 U.S. at 117:

> [A] constitution is not intended to embody a particular economic theory, whether of paternalism and the organic relation of the citizen to the State or of laissez faire. It is made for people of fundamentally different views, and the accident of our finding certain opinions natural and familiar or novel or even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States.

Despite the sustained debate among the States and eminent legal commentators over the conflicting socioeconomic theories underlying the competing informed consent models of "physician paternalism" and "patient autonomy," the lower federal courts have not hesitated to con-

clude that abortion related statutes embodying the "patient autonomy" model conflict with the Constitution of the United States. In their view, the Constitution enacts, if not Mr. Herbert Spenser's *Social Statics*, Sir William Osler's *Aequanimitas and Other Addresses* (1904) (the classic work on medical ethics which strongly advocates physician paternalism).

No matter how compelling may be that set of disquisitions on the augustly paternalistic role of the physician, however, it has no proper claim to decide forever informed consent policy for the nation in lieu of the more democratically responsive state and local legislatures.

Whatever standards this Court may enunciate to govern statutes designed to ensure informed consent to abortion, they should not be such as will freeze in constitutional concrete the "physician paternalism" approach, so as to ban forever and altogether continued experimentation and debate concerning the alternative approach which seeks to foster patient autonomy.

Respectfully submitted,

Counsel for Amicus
JAMES ARTHUR GLEASON 216-771-5466
The Park Building
Cleveland, Ohio 44114

MARY ANN JOHANEK 216-447-9050
Two Rockside, 77 Center
6000 N. Creek Rd., Suite 15
Independence, Ohio 44131

THOMAS J. KEENAN 216-566-7550
Statler Office Tower, Suite 870
Cleveland, Ohio 44115

JOSEPH P. MEISSNER 216-687-1900
1223 W. Sixth St.
Cleveland, Ohio 44113

Of Counsel:
Americans United For Life
Legal Defense Fund
230 N. Michigan, Suite 915
Chicago, IL 60601
312/263-5029

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APPENDIX: NOTES TO TABLE OF CURRENT POSITIONS ON THE APPROACH TO INFORMED CONSENT BY STATE

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[1] ALABAMA. *Roberts* v. *Wood*, 206 F.Supp. 579 (S.D. Ala. 1962).

[2] ALASKA. *Poulin* v. *Zoitman*, 542 P.2d 251 (Alaska 1975); *Patrick* v. *Sedwick*, 391 P.2d 453 (Alaska 1964); Alaska Stat. §09.55.556 (Supp. 1981). The common law standard of disclosure is not adequately articulated in these two cases. However, the statute requires that a physician disclose common risks and reasonable alternatives to the proposed treatment. The health care provider may limit the extent of the information disclosed if he reasonably believes that a full disclosure would have an adverse effect on the patient's condition.

[3] ARIZONA. *Shetter* v. *Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (Ct. App. 1965). Note, however, that even though Arizona follows a "physician paternalism" rule, the court said that the consenter must understand substantially the nature of the surgical procedure attempted and the probable results of the operation.

[4] ARKANSAS. *Regram* v. *Sisco*, 406 F.Supp. 776 (W.D. Ark. 1976).

[5] CALIFORNIA. *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); California applies the "patient autonomy" approach with respect to any potential of death or serious harm; beyond such risks, disclosure is required according to the "physician paternalism" rule.

[6] COLORADO. *Mallett* v. *Pirkey*, 171 Colo. 271, 466 P.2d 466 (1970). Though the rule in Colorado falls under a "physician paternalism" model, the burden rests upon the doctor to prove, if challenged, that his behavior conformed to acceptable standard physician practice.

[7] CONNECTICUT. To date, Connecticut has no law on informed consent.

[8] DELAWARE. *Coleman* v. *Garrison*, 349 A.2d 8 (Del. 1975); Del. Code Ann. tit. 18, §§6851-6852 (Supp. 1980).

[9] DISTRICT OF COLUMBIA. *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

[10] FLORIDA. *Ditlow* v. *Kaplan*, 181 So.2d 226 (Fla. Dist. Ct. App. 1965); *Bowers* v. *Talmadge*, 159 So. 2d 888 (Fla. Dist. Ct. App. 1964); Fla. Stat. Ann. §768.46 (West Supp. 1982). Under the Florida statute, a physician may disclose information in accordance with accepted medical practice, but that degree of disclosure must be sufficient to permit a reasonable individual to have a general understanding of the procedure, acceptable alternative treatments, and any substantial risks and hazards recognized as inherent in the procedure. *Accord Bowers* v. *Talmadge*, but *Ditlow* v. *Kaplan* holds that a doctor who advises a patient that a procedure is serious and "risky" should be discharged unless the plaintiff presents expert testimony that it is the custom to volunteer more detailed information.

[11] GEORGIA. *Young* v. *Yarn*, 136 Ga. App. 737, 222 S.E.2d 113 (Ct. App. 1975); Ga. Code Ann. §§88-2901 to -2907 (1979). Not applicable to abortion and sterilization.

[12] HAWAII. *Nishi* v. *Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970); Hawaii Rev. Stat. §§671-73 (1976). The statute fails to specify the standard by which the adequacy of the physician's disclosure is to be measured. The statute empowers the state board of medical examiners to establish these standards. Under *Nishi*, a "physician paternalism" rule was adopted, but that standard could be superceded by the medical board requirements.

[13] IDAHO. *LePlelly* v. *Grefenson*, 101 Idaho 422, 614 P.2d 762 (1980); Idaho Code §18-609 (Supp. 1982), §§39-4301 to -4306 (1977). Under *LePlelley*, though the "physician paternalism" rule is adopted, the court held that when relatively complicated surgery is involved a physician must disclose known risks of death or serious bodily injury. Although §§39-4301 to -4306 adopt a "physician paternalism" approach, they do not apply to abortion procedures. A "patient autonomy" approach to abortion is provided in §18-609.

[14] ILLINOIS. *Green* v. *Hussey*, 127 Ill. App. 2d 174, 263 N.E. 2d 156 (App. Ct. 1970); Ill. Rev. Stat. ch. 38, §81-23.2 (1981). Though *Green* adopts the "physician paternalism" rule, Illinois statutory law adopts the "patient autonomy" approach for abortion procedures.

[15] INDIANA. *Joy* v. *Chau*, 377 N.E.2d 670 (Ind. Ct. App. 1978). The *Joy* court held that a physician is to make a reasonable disclosure to his patient, but failed to adopt either of the two rules.

[16] IOWA. *Grosjean* v. *Spencer*, 258 Iowa 685, 140 N.W. 2d 139 (1966); Iowa Code Ann. §147.137 (West Supp. 1982-83). Prior to the adoption of the statute, Iowa followed the "physician paternalism" rule. Though the statute cannot be classified as following either of the two rules, it does require the physician to disclose the nature and purpose of the proposed treatment and the known risks if they are included in a specified list of serious dangers.

[17] KANSAS. *Natanson* v. *Kline*, 186 Kan. 393, 350 P.2d 1093 (1960).

[18] KENTUCKY. *Holton* v. *Pfingst*, 534 S.W.2d 786 (Ky. 1975); *Bennett* v. *Graves*, 357 S.W.2d 893 (Ky. Ct. App. 1977); Ky. Rev. Stat. Ann. §§304.40-320 (Baldwin 1981). *Bennett* and *Holton* adopt the "physician paternalism" rule. However, the statutory provisions adopted after *Holton* require that information be provided to the patient such that "a reasonable individual . . . would have a general understanding of the procedure and . . . acceptable alternative procedures . . . and substantial risks and hazards inherent in the proposed treatment. . . ."

[19] LOUISIANA. *Percle* v. *St. Paul Fire and Marine Ins. Co.*, 349 So.2d 1289 (La. Ct. App. 1977); La. Rev. Stat. Ann. §40:1299.40 (West. 1977).

[20] MAINE. *Woolley* v. *Henderson*, 418 A.2d 1123 (Me. 1980); Me. Rev. Stat. Ann. tit. 24, §2905 (Supp. 1981-1982).

[21] MARYLAND. *Sard* v. *Hardy*, 281 Md. 432, 379 A.2d 1014 (Ct. App. 1977).

[22] MASSACHUSETTS. *Schroeder* v. *Lawrence*, 372 Mass. 1, 359 N.E.2d 1301 (1977); *Haggerty* v. *McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962). It appears that Massachusetts follows the "physician paternalism" standard. However, the cases do not expressly address the standard for disclosure. Though *Haggerty* refers to the "physician paternalism" standard, the more recent *Schroeder* case cited *Canterbury* v. *Spence* and appeared to commend its reasoning.

[23] MICHIGAN. *Roberts* v. *Young*, 369 Mich. 133, 119 N.W.2d 627 (1963).

[24] MINNESOTA. *Plutshack* v. *University of Minn. Hospitals*, 316 N.W.2d 1 (Minn. 1982); *Cornfeldt* v. *Tongren*, 262 N.W. 2d 684 (Minn. 1977); Minn. Stat. Ann. §144.651 (West Supp. 1982).

[25] MISSISSIPPI. *Ross* v. *Hodges*, 234 So.2d 905 (Miss. 1970).

[26] MISSOURI. *Aiken* v. *Carey*, 396 S.W.2d 668 (Mo. 1965).

[27] MONTANA. *Negaard* v. *Estate of Feda*, 152 Mont. 47, 446 P.2d 436 (1968).

[28] NEBRASKA. No case law. Neb. Rev. Stat. §44-2816 (1978).

[29] NEVADA. *Corn* v. *French*, 71 Nev. 280, 289 P.2d 173 (1955); Nev. Rev. Stat. §41A.110 -.120 (1981). Under the Nevada statute, neither the "physician paternalism" nor "patient autonomy" rules are adopted. Instead the statute delineates information that must be provided for patient consent. These include the general nature of the procedure to be undertaken, its risks, and any alternative treatments feasible. To that extent, the statute follows the "patient autonomy" rule.

[30] NEW HAMPSHIRE. *Folger* v. *Corbett*, 118 N.H. 737, 394 A.2d 63 (1978); N.H. Rev. Stat. Ann. §507-C (Supp. 1981). Declared void by Supreme Court of New Hampshire in *Carson* v. *Maurer*, 120 N.H. 925, 424 A.2d 825 (1980).

[31] NEW JERSEY. *Kaplan* v. *Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd* 51 N.J. 404, 241 A.2d 235 (1968).

[32] NEW MEXICO. *Henning* v. *Parsons*, 95 N.M. 454, 623 P.2d 574 (1981).

[33] NEW YORK. *Karlsons* v. *Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App.Div. 1977); N.Y. Public Health Law §2805-d (McKinney Supp. 1982).

[34] NORTH CAROLINA. *Butler* v. *Berkeley*, 25 N.C. App. 325, 213 S.E.2d 571 (Ct. App. 1975); N.C. Gen. Stat. §90-21.13 (1981). Under the statute, a disclosure consistent with general medical practice is sufficient only if such disclosure gives the patient a general understanding of the treatment and its recognized risks.

[35] NORTH DAKOTA. *Walker* v. *North Dakota Eye Clinic*, 415 F.Supp. 891 (D.N.D. 1976); N.D. Cent. Code §26-40.1-04 to -05 (1978). Statute declared unconstitutional in *Arneson* v. *Olsen*, 270 N.W.2d 125 (N.D. 1978).

[36] OHIO. *Congrove* v. *Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (Comm. Pleas 1973); Ohio Rev. Code Ann. §2317.54(A) (Baldwin Supp. 1981).

[37] OKLAHOMA. *Lambert* v. *Park*, 597 F.2d 236 (10th Cir. 1979); *Martin* v. *Stratton*, 515 P.2d 1366 (Okla. 1973). The *Martin* court failed to adopt either of the two rules. In *Lambert*, however, the Tenth Circuit adopted the "patient autonomy" rule for Oklahoma. After discussing several reasons for adopting the "patient autonomy" approach the court said:

> We have chosen between the tests only because the Oklahoma Court has indicated it would do so. The Court need not, however, consider itself so limited. The better practice would be to adopt a rule allowing for the application of whichever test best comports with the theories of the parties and the evidence produced during the trial.

Lambert v. *Park*, 597 F.2d at 299.

[38] OREGON. *Holland* v. *Sisters of St. Joseph of Peace*, 270 Or. 129, 522 P.2d 208 (1974); Or. Rev. Stat. §677.097 (1981).

[39] PENNSYLVANIA. *Jeffries* v. *McCague*, 242 Pa. Super. 76, 363 A.2d 1167 (Super. Ct. 1976); *Cooper* v. *Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); Pa. Stat. Ann. tit. 40, §1301.103 (Purdon Supp. 1982).

[40] PUERTO RICO. *Torres Perez* v. *Hospital Doctor Susoni*, 95 P.R.R. 845 (1968).

[41] RHODE ISLAND. *Wilkinson* v. *Vesey*, 110 R.I. 606, 295 A.2d 676 (1972), R.I. Gen. Laws §9-19-32 (Supp. 1981).

[42] SOUTH CAROLINA. *Walker* v. *Pierce*, 560 F.2d 609 (4th Cir. 1977). To date, no standard has been enunciated in South Carolina.

[43] SOUTH DAKOTA. *Cunningham* v. *Yankton Clinic*, 262 N.W.2d 508 (S.D. 1978). To date, no standard has been enunciated in South Dakota.

[44] TENNESSEE. *Longmire* v. *Hoey*, 512 S.W.2d 307 (Tenn. Ct. App. 1974); Tenn. Code Ann. §29-26-118 (1980).

[45] TEXAS. *Karp* v. *Cooley*, 493 F.2d 408 (5th Cir. 1974); *Wilson* v. *Scott*, 412 S.W.2d 299 (Tex. 1967); Tex. Rev. Civ. Stat. Ann. art. 4590; §§6.03-.07 (Vernon Supp. 1982), implemented by 3 Tex. Reg. 4293 (1978). Though *Wilson* makes it clear that the "physician paternalism" approach applies, under the statute a state board promulgates rules that govern the degree of disclosure necessary for certain types of medical procedures.

[46] UTAH. *Ficklin* v. *McFarlane*, 550 P.2d 1295 (Utah 1976); Utah Code Ann. §78-14-5 (1977).

[47] VERMONT. *Small* v. *Gifford Memorial Hospital*, 133 Vt. 552, 349 A.2d 703 (1975); Vt. Stat. Ann. tit. 12, §1909 (Supp. 1981). Under *Small*, the Vermont Supreme Court adopted the "patient autonomy" approach. The statute, however, though prescribing the elements of information that must be disclosed—i.e. the alternatives to the treatment or diagnosis and the risks and benefits involved—incorporates these requirements in a "physician paternalism" approach.

[48] VIRGINIA. *Bly* v. *Rhonds*, 216 Va. 645, 222 S.E.2d 783 (1976).

[49] WASHINGTON. *Miller* v. *Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (Ct. App. 1974), *aff'd*. 85 Wash. 2d 151, 530 P.2d 334 (1975); Wash. Rev. Code Ann. §§7.70.050-.060 (Pocket Part 1982).

[50] WEST VIRGINIA. No law.

[51] WISCONSIN. *Trogun* v. *Fruchtman*, 58 Wis.2d 569, 207 N.W.2d 297 (1973).

[52] WYOMING. *Govin* v. *Hunter*, 374 P.2d 421 (Wyo. 1962).

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1982

Nos. 81-746 and 81-1172
AKRON CENTER FOR REPRODUCTIVE
HEALTH, INC., et al.

vs.

CITY OF AKRON, et al.

ON CERTIORARI TO THE UNITED STATES COURT
OF APPEAL FOR THE SIXTH CIRCUIT

BRIEF OF WOMEN LAWYERS OF SACRAMENTO, PLACER COUNTY WOMEN LAWYERS, AND AUBURN WOMEN'S CENTER

Nancy Reardan
2018 19th Street
Sacramento, California 95818
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TABLE OF CONTENTS

Table of Authorities.....i

Interest of Amici Curiae and Consent.....1

Introduction.....2

Argument:

I. The Akron Statutes Create a Double Standard.....7

A. Sexual Active Men and Women Under Age 18 Are Treated Differently.....7

B. The Parental Consent Requirement Stigmatizes and Punishes Minor Women.....9

II. Because an Unwanted Pregnancy per se Constitutes a Burden on a Woman, Medically Unnecessary Restrictions on Pregnancy Terminations Violate Equal Protection.....12

A. Pregnancy Itself Constitutes a Burden on Women.....12

1. Physical Burden..12

2. Lack of Adequate Medical Care.....14

3. Parenthood and Poverty.....16

4. Cumulative Burden.....21

III. Akron Has Failed to Demonstrate That Parental Consent Furthers an Important Governmental Interest Substantially Related to the Gender Classification.....22
A. The Parental Consent Requirment Fails To Promote the City's Interest in Maternal Health.....23
B. Parental Consent Requirements Do Not Serve the City's Interest in Protecting Family Integrity.....25

IV. The Statute Mandating Hospitalization for Pregnancy Terminations Creates Unnecessary Classification Schemes Based on Gender.....27
A. Akron's Hospitalization Requirments Apply Only To Pregnancy Terminations And Not To All Surgeries With Similar Risks.....27
B. Sanctions Against Performing Pregnancy Terminations In Non-Hospital Facilities Result In Invidious Discrimination.....32

Conclusion.....44

TABLE OF AUTHORITIES

CASES

Bellotti v. Baird
428 U.S. 128 (1976).....31

Califano v. Wescott
443 U.S. 76 (1979).....7

Carey v. Population Services
431 U.S. 684 (1977).....31

Craig v. Boren
429 U.S. 190 (1976).....7, 31

Doe v. Bolton.....28, 29, 30
410 U.S. 438 (1978).....32, 37, 41

Eisenstadt v. Baird
405 U.S. 438 (1972).....4

Friendship Medical Center v.
Chicago Board of Health 505 F.2d
1141 (7th Cir. 197) cert. den.
420 U.S. 997 (1974).....30, 41

Frontiero v. Richardson
411 U.S. 677 (1973).....7

Griswold v. Connecticut
381 U.S. 479 (1965).....4

H.L. v. Matheson
450 U.S. 398 (1981).....11, 24, 27

Harris v. McRae
448 U.S. 297 (1980).....4, 17

Mahoning Women's Center v. Hunter
444 F. Supp. 12 (N.D. Ohio 1977)..37

Michael M. v. Sonoma County Superior Court 450 U.S. 464 (1981)...19

Mississippi University for Women v. Hogan.....7, 11, 23
50 USLW 5068 (1982).....33, 35, 42

Orr v. Orr
440 U.S. 268 (1979).....40

Planned Parenthood v. Ashcroft
664 F.2d 687 (8th Cir, 1981).....26

Planned Parenthood v. Danforth
428 U.S. 42 (1976).....30

Reed v. Reed
414 U.S. 71 (1971).....7

Roe v. Wade
410 U.S. 113 (1973).....4, 35, 41

Warth v. Seldin
422 U.S. 490 (1975).....31

Wengler v. Druggist Mutual Insurance Co.....7, 23
46 U.S. 142 (1980).....33, 40

Word v. Poelker
495 F.2d 1349 (8th Cir. 1974).....41

STATUTES

Utah Code Ann. §76-7-304

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The American Promise: Equal Justice and Economic Opportunity Report, Council on Economic Opportunity (1981).....19

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Dallek, Geraldine, Maternal Health Care in America: Sliding Back Down the Mountain, Santa Monica - National Health Law Project, 1981.....16, 17

Karst, Kenneth "Forward: Equal Citizenship Under the Fourteenth Amendment" 91 Harvard Law Review 1 (1978).....9

Pearce, Diana "The Feminization of Poverty" Urban and Social Change Review (Feb 1978).....19

Regan, Donald "Rewriting Roe v. Wade" 77 Michigan Law Review 1569 (1979).....12

INTEREST OF AMICI CURIAE AND CONSENT

The named county women lawyers associations are membership organizations consisting of women and men who seek elimination of sex discrimination through the legal profession. Members represent clients in California who have suffered gender discrimination in violation of federal protection under the Fourteenth Amendment of the U.S. Constitution.

Amici are concerned that the federal provisions that assure equal protection for all citizens are being unduly restricted by laws which create a double standard by requiring emancipation or parental consent for minor women seeking pregnancy terminations, and not for minor men, and which impose medically unnecessary burdens on women.

Amici are familiar with the scope and presentation of arguments which have been advanced by Amici Women Lawyers Association of Los Angeles and California Women Lawyers and concur in these arguments.

This brief is filed pursuant to Rule 36 of the Rules of the Supreme Court of the United States. Consent to the filing of the brief has been given by attorneys for both parties.

INTRODUCTION

This case asks difficult questions about the extent to which a government may impose burdens, in the guise of "protections," on women because they are women. This brief posits that the asserted justifications for the restrictions at issue are a sham, and that the

additional and unusual burdens imposed by the City of Akron on a woman's right to terminate her pregnancy are unsupportable under our Constitution as previously interpreted by this Court.

The authors of this brief acknowledge to the Court and to the world that women are biologically different from men. We acknowledge that only women can become pregnant. A fortiori, we believe, only the woman can decide to terminate her pregnancy.

This Court has recognized that principle. This Court has characterized the decision to terminate a pregnancy as one that is personal to a woman and her physician. The Court has instructed the nation that privacy in the exercise of that decision is constitutionally required.

This brief questions the extent to which a city may heap unusual medical, financial, familial and social requirements on the exercise of this particular medical decision. Amici ask the Court to consider whether laws imposing these burdens should be permitted to escape strict scrutiny under the Equal Protection Clause of the United States Constitution for no other reason than that the basic burden - - the pregnancy - - can fall upon women alone.

The Court has repeatedly held that the fundamental right to privacy in matters involving contraception, marriage and the right to procreate shall not be infringed. Harris v. McRae 448 U.S. 297 (1980); Roe v. Wade 410 U.S. 113 (1973); Eisenstadt v. Baird 405 U.S. 438 (1972); Griswold v. Connecticut 381 U.S. 479 (1965).

The instant statute allows the City to infringe on this fundamental right by placing unnecessary burdens only on the procreative choice of females. Women, but not men, must (1) if they are minors, obtain their parents' consent for a pregnancy termination; (2) incur the expense of hospitalization for second trimester terminations; and (3) be subjected to unnecessary physician counseling. Amici address in this brief the most pernicious of these requirements: mandatory parental approval for minor females, mandatory physician counseling, and mandatory hospitalization.

Amici respectfully request the Court's recognition of the fact that pregnancy in itself is an unusual physical, personal and financial burden, and that the burden falls hardest on unmar-

ried, poor, minor women. Amici ask the Court to imagine the stress of nine months of unwanted pregnancy, and to be mindful of the life prospects for an unwanted child. Amici ask the Court to avoid burdening women with a duty imposed on no other person under the law. Amici respectfully urge this Court to strike down laws which individually and collectively impinge upon a woman's right to terminate her pregnancy and which have, until now, avoided scrutiny because the suffering falls only on one sex.

ARGUMENT

I

THE AKRON ORDINANCES CREATE A DOUBLE STANDARD.

A. Sexually Active Men And Women Under Age 18 Are Treated Differently.

Gender-based classifications may not be based on archaic assumptions about the proper role of the sexes. Reed v. Reed 404 U.S. 71 (1971); Frontiero v. Richardson 411 U.S. 677 (1973); Craig v. Boren 429 U.S. 190 (1976); Califano v. Wescott 443 U.S. 76 (1979); Wengler v. Druggist Mutual Insurance Co. 446 U.S. 142 (1980); and Mississippi University for Women v. Hogan ___ U.S. ____, 50 USLW 5068, 5070 (July 1, 1982,).

In Akron, unemancipated young women who become pregnant are burdened by regulations which require parental consent to the decision to terminate a pregnancy. Even if these young women are emancipated, their parents must still consent, except upon a court's order that the pregnancy be terminated. Young men, though equally responsible and interested in the pregnancy, are subject to no similar regulation.

By omitting young men from the purview of this statute, Akron implies that young men are sufficiently mature to regulate their procreative activity and therefore not in need of parental guidance or supportive conversation. The parents of sexually active young men under 18 may never know of their sons' responsibility for resultant pregnancies.

These provisions allow young men to abrogate their responsibilities and serve only to perpetuate the double standard which permits men to be sexually active but requires that women be chaste or suffer the consequences.

B. The Parental Consent Requirement Stigmatizes and Punishes Minor Women

The psychological burden of an unwanted pregnancy effectively stigmatizes young women.

Kenneth Karst in "Equal Citizenship Under the Fourteenth Amendment" 91 Harvard Law Review 1, 57 (1977) states that women will achieve equal citizenship only when the judiciary rejects the symbolism of dependency. However, Karst points out this will not occur as long as:

> (1) our society's traditional double standard of sexual morality . . . places a greater stigma on unmarried women who become pregnant, than on the men who father their children; (2) our society's continuing expectation is that women take the major responsibility for contraception and childcare. Id., 37.

As long as the City of Akron continues to place burdens solely on women, it supports this double standard for men and women and stigmatizes women.

Karst points out that when one person is singled out for treatment which places her in a dependent status, e.g. by requiring a young woman seeking a pregnancy termination to notify her parents, her identity is damaged. Enforced dependency results in second-class status. The young woman becomes a victim who "suppresses aspirations that look unattainable when seen with the restricted vision imposed by a withered self-concept." Id., 7.

As long as women must suffer medically unnecessary, legislatively-imposed restrictions, but men need not, women are stigmatized, and men escape unscathed for the same conduct. Such restrictions "reflect archaic and stereotypic notions". Mississippi University for Women v. Hogan, supra, 50 U.S.L.W., 5070.

It is established that "the absolute nature of the statutory requirement. . . violates the requirement that regulation in this fundamentally personal area be carefully tailored to serve significant [governmental] interests." H.L. v. Matheson, supra, 450 U.S. 446. However, given the social stigma and medical dangers involved in childbirth for minor women, to preclude termination of an unwanted pregnancy because of statutorily imposed parental intervention not only

fails to serve such an interest, but also serves only to punish pregnant minors. Men, no matter what age, are not subject to similar parental intervention.

II

BECAUSE AN UNWANTED PREGNANCY PER SE CONSTITUTES A BURDEN ON A WOMAN, MEDICALLY UNNECESSARY RESTRICTIONS ON PREGNANCY TERMINATIONS VIOLATE EQUAL PROTECTION.

A. Pregnancy Itself Constitutes A Burden On Women

1. Physical Burden

Donald H. Regan, in "Rewriting Roe v. Wade" 77 Michigan Law Review 1569 (1979) fills four pages with the ordinary complaints which accompany any pregnancy. From faintness and nausea to the risk of death in childbirth, virtually all women must "...put up with enough pain, discom-

fort and disruption of appearance and emotional city to add up to a major burden."

Regan further states, "It is worth mentioning that all of the pains and discomforts listed above are likely to be aggravated when the entire pregnancy is unwanted. It is much easier to bear up under pain and inconvenience when they serve some end one has chosen than when they do not...." Id., 1582.

Regan discusses the equal protection aspects of pregnancy termination through the use of a "good samaritan" tort analysis. Id., 1636. No person has a duty to come to the assistance of any other person except in the abortion context, where a woman is required to sacrifice herself for a fetus. The city's interest in potential life can never justify forcing

a woman to risk her health for another life. Id., 1640. No woman should be forced by any other person or the city to bear children. This is symptomatic of a totalitarian society that does not support "constitutional values [such as] non-subordination, freedom from physical invasion, and equal protection." Id., 1639.

2. Lack Of Adequate Medical Care

In addition to the personal physical burden of pregnancy, women experience difficulty in obtaining medical care. In many parts of the country, family planning and prenatal services are virtually nonexistent. In March 1982, the State of California reported that basic obstetric and gynecologic services from high quality fee-for-service physicians and private

hospitals are unavailable to all but the most affluent. California Department of Consumer Affairs, Pregnant Women and Newborn Infants: A Deepening Crisis in Health Care.

The consequences of inadequate access are seen most graphically in comparisons of infant mortality rates. For example, the infant mortality rate in Scandinavian countries is six per one thousand.*

In California, the infant mortality rate is 12.3 per one thousand for white infants. This rate doubles in medically underserved areas: for example, for Black infants in Oakland, the rate is

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*This rate correlates with national health insurance programs which provide coverage for all pregnancies and all pregnancy terminations, plus universal access to contraceptives, irrespective of age.

23.6 per 1,000; for Hispanic infants at L.A. County Medical Center, 25 per 1,000; and for infants born in rural El Dorado County, 23 per 1,000. Lower rates of infant mortality correspond to prenatal care during the first trimester. Dallek, Geraldine, "Maternal Health Care in America: Sliding Back Down the Mountain," National Health Law Project, 1981,5.

This lack of adequate care constitutes a burden on pregnancy over which pregnant women have no control. It is another burden in the area of procreative freedom which affects only women.

3. Parenthood And Poverty

Financial barriers compound the demographic/geographic lack of access to medical care.

The Supreme Court in Harris v. McRae 448 U.S. 297 (1980) held that the federal government may choose to fund childbirth and not pregnancy termination. Since then, governmental financial policies have effectively denied access to health care during pregnancy for significant numbers of women.

Even childbirth in hospitals is precluded for financial reasons. Hospital imposed financial restrictions often include requiring deposits or Medicaid co-payments, and requiring on-staff referring doctors for admission or doctors who will accept Medicaid patients.

Dallek's study, "Maternal Health Care" etc., supra found that financial constraints alone, without additional restrictions, resulted in more than fifty percent of all children in Brownsville,

Texas being born outside hospitals. Dallek also documents that nineteen citys do not cover first-time pregnant women under their Medicaid programs.

In many areas it is not unusual for all but government-funded hospitals to reject women in labor. These institutions often go bankrupt because indigent care drains the financial resources of the state or local government. In California, between 1970 and 1980, 24 out of 57 county hospitals were closed for this reason.

Thus, the irony of governmental refusal to pay for pregnancy termination compounds the ignominy of its refusal to pay for childbirth and prenatal care in a hospital or clinic.

The National Advisory Committee on Economic Opportunity in "The American

Promise: Equal Justice and Economic Opportunity," (1981) concluded that over fifty percent (217,000) of all poor families are headed by women.

In a seminal article, "The Feminization of Poverty: Women, Work and Welfare," Urban and Social Change Review (February, 1978), Diana Pearce outlines the shift of poverty from two-parent households to women-headed households in the 1980's. More than forty-six percent of these women were never married and a majority of them did not see a doctor at all until the second trimester of pregnancy.

This Court noted the link between poverty and teenage pregnancy in Michael M. v. Sonoma 450 U.S. 470 fn.3 and 4, citing the Alan Guttmacher Institute's 11 Million Teenagers, at 10, 13, 23, 25.

Frequently undereducated because they left school as a result of unwanted pregnancies, these women barely subsist on Aid For Dependent Children (AFDC) programs.*

The physical, financial and personal burdens of pregnancy are magnified when the pregnancy is unwanted, or when it befalls a minor, unmarried woman. Even in the absence of any statutory restrictions, an unwed woman seeking a pregnancy termination must overcome severe hurdles. Initially, she must find a doctor who will see her to determine whether she is

*These programs range from $26.00 per person per month in Mississippi to $119.00 per person per month in New York. The average for the nation is $5,318.00 for families on welfare compared with the $21,703.00 national median income of two-parent working families.

pregnant. In rural areas of the U.S. and in medically underserved urban areas, it may be difficult to locate a local doctor. A woman frequently must travel to a distant community that provides obstetric and gynecological care. She is therefore faced with transportation and lodging expenses. If an individual is indigent, the number of doctors taking Medicaid is severely restricted because these rates are below private rates. All of these factors serve only to delay, thereby increasing the duration of the procedure, the cost of medical treatment, the psychological damage, and the chance of maternal death.

4. **Cumulative Burden**

As herein demonstrated, any unwanted pregnancy constitutes a burden on women. The additional burdens imposed by the

proposed ordinances increase these financial, physical and psychological burdens by requiring hospitalization, imposing medically unnecessary procedures and extraordinary counseling, requiring a 24-hour delay and parental consent for minor women.

III

AKRON HAS FAILED TO DEMONSTRATE THAT PARENTAL CONSENT FURTHERS ANY IMPORTANT GOVERNMENTAL INTEREST SUBSTANTIALLY RELATED TO THE GENDER CLASSIFICATION

Among the interests proffered by the City in justification of the gender classification inherent in the consent requirement are the protection of maternal health and the promotion of family integrity. These interests are spuriously asserted in this instance.

A. The Parental Consent Requirement Fails To Promote the City's Interest in Maternal Health.

City policies that discriminate on the basis of gender must show that the classification serves "important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives. " Wengler v. Druggists Mutual Insurance Co., 446 U.S. 142, 150. The classification must assist "members of the sex that is disproportionately burdened." Mississippi University for Women v. Hogan, 50 U.S.L.W. 5069.

Parental consent in Akron is an absolute barrier to pregnancy terminations performed in hospitals, because all hospitals require this consent.

Akron has failed to make any showing that a substantial governmental interest in maternal health is furthered by the parental consent requirement. The City implies that only parental consent can foster maternal health indirectly by promoting parental guidance on the topic of pregnancy. Allegedly, the ordinance, like the Utah statute in H.L. v. Matheson, supra 450 U.S. 424, "would tend to facilitate communication between daughters and parents."

However, the Court in H.L. failed to mention the parental communication which might prove helpful between the male, who must share the responsibility for the pregnancy, and his parents. This type of statute thus assumes that female minors are unable to make decisions regarding contraception and pregnancy, while male

minors are able to so decide. This distinction is unjustified by any showing made by Akron, especially in light of the generally-accepted premise that females mature earlier than males.

During the second trimester of gestation, each day of delay pushes the pregnant woman into greater medical danger. The stated purpose of protecting maternal health certainly is not achieved under this ordinance.

If mandated parental consent does, in fact, support a substantial interest in communication between parents and children concerning pregnancy, then parents of minor males must also logically be notified.

B. Parental Consent Requirements Do Not Serve the City's Interest in Protecting Family Integrity.

News reports daily confirm that young women are subject to sexual assault by fathers, step-fathers, other male relatives and boyfriends (See, e.g., Sacramento Bee, July 14, 1982; See also Planned Parenthood Association of Kansas City v. Ashcroft, 655 F.2d 848,859, fn. 13 (1981), where data is cited showing that 50% of children age 12 and younger who seek abortions are incest victims.) Others are victims of child abuse, parental alcoholism and drug abuse, mentally ill parents, and the stresses accompanying divorce. Forced communication between pregnant minor females and parents who endanger these children can hardly be deemed to promote family integrity.

According to Justice Marshall, dissenting in H.L. v. Matheson, supra 450 U.S. 448, the purpose of cases protecting parental authority is to protect the family from governmental intrusion, not to justify mandatory governmental intrusions. "Whatever its motive, [governmental] intervention is hardly likely to resurrect parental authority that the parents themselves are unable to preserve."

IV

THE ORDINANCE MANDATING HOSPITALIZATION FOR PREGNANCY TERMINATIONS CREATES AN UNNECESSARY CLASSIFICATION SCHEME BASED ON GENDER.

A. Akron's Hospitalization Requirements Apply Only To Pregnancy Terminations And Not To All Surgeries With Similar Risks.

Although states often seek to protect the health and well-being of their citizens by requiring physicians to be examined and licensed by the City and by requiring hospitals and clinics to meet various building and inspection standards for licensure, states do not generally substitute legislative dictates for a physician's judgment on how best to medically treat a specific patient. See Doe v. Bolton, 410 U.S. 179, 199 (1973). Rather, the emphasis in our society has been precisely opposite, that is, to encourage and respect the physician's judgment and expertise in medical areas. As this Court has previously stated,

> "...medical judgment may be exercised in the light of all factors [such as] physical, emotional, psychological, familial, and the woman's age - relevant to the well-being of the patient.... This allows the attending physician the room he needs to make his best medical judgment. And

it is room that operates for the benefit, not the disadvantage, of the [patient]." Id., 192.

Yet, Akron has attempted to impose its legislators' decisions in place of the doctor's best medical judgment concerning the health of the patient. No other surgical or medical procedures are so burdened. Thus, a doctor may assess, free from the chill of statutory prohibitions, all relevant factors pertaining to the health of the individual patient when determining whether to perform a vasectomy, a commonly used male sterilization procedure, in a medical office, a clinic or a hospital. If a doctor does not exercise adequate medical judgment and a patient is injured because a procedure is improperly performed on an out-patient basis, then the doctor will be subject to civil liabilities, Doe v. Bolton, 410 U.S. at 199.

Under the Akron law, however, if a doctor weighs all the factors relating to the health of his patient and, in the exercise of sound medical judgment, elects to perform a pregnancy termination in an office or a clinic, that election will have violated the legislative proscription. To isolate pregnancy terminations in this way "treats differently, without a compelling reason, medical procedures which in terms of health risk are not distinguishable." Friendship Medical Center v. Chicago Board of Health, 505 F.2d 1141, 1153 (7th Cir.) cert. denied 420 U.S. 997 (1974). Such differential treatment violates the Equal Protection Clause of the Fourteenth Amendment. See Doe v. Bolton, supra, 410 U.S. 194; Planned Parenthood of Akron v. Danforth, 428 U.S. 52, 77-78 (1976);

Bellotti v. Baird, 428 U.S. 128, 149-150 (1976).

In the instant case, not only is the differential treatment violative of equal protection rights, but also, since ordinances differ from city to city, pregnant women will be affected differently depending upon where they live.

The ordinance challenged here does not directly regulate the conduct of women seeking second trimester abortions. However, this Court has consistently recognized that restricting the operations of providers of goods or services may "result indirectly in the violation of third parties' rights." Warth v. Seldin, 422 U.S. 490, 510 (1975); Carey v. Population Services International, 431 U.S. 684, 694 (1977); Craig v. Boren, 429 U.S. 190, 195 (1976).

In the instant case, a female patient seeking pregnancy termination would be denied "the right to receive medical care in accordance with her licensed physician's best judgment" and the physician would be denied " the right to administer it." Doe v. Bolton, 410 U.S. at 197.

There is no similar context in which a class of male patients has been denied the medical care which a physician deems best for the particular patient. Such differential treatment establishes a statutory classification that distinguishes between males and females solely on the basis of gender.

B. Sanctions Against Performing Pregnancy Terminations In Non-hospital Facilities Result In Invidious Discrimination.

This Court has repeatedly held that "gender-based discriminations must serve important governmental objectives and that the discriminatory means employed must be substantially related to the achievement of these objectives." Wengler v. Druggists Mutual Insurance Co., supra, 446 U.S. 142, 150

The alleged city interest in the hospitalization requirement at issue is maternal health. Akron has the burden of showing a direct and substantial relationship between the hospital requirement and the objective of protecting maternal health. Mississippi University for Women v. Hogan, ___ U.S. ___, 50 U.S.L.W. 5068, 5070. Akron has failed to satisfy this burden.

There is no evidence in this case that licensed physicians in Akron are

incapable of making reasoned decisions when selecting medical settings for the performance of minor surgery. Yet the city, to rationalize its ordinance, must believe that doctors are competent to select proper settings for all types of surgery except pregnancy terminations.

Akron has failed to establish that licensed physicians are incompetent in caring for these patients. This Court is respectfully requested to find that licensed physicians exercise the same degree of care in determining which patients to hospitalize irrespective of the medical condition of the patient.

The necessary inference derived from the ordinance that physicians who perform pregnancy terminations are less competent than other physicians, is a mechanical application of an inaccurate stereotype

about the need of women for special protection. Further, such a legislative judgment has been held improper. Mississippi University of Women v. Hogan, supra ___ U.S. ___, 50 U.S.L.W. 5070. In the era of back-alley and kitchen-table abortions and less sophisticated medical procedures, a legislative body may have had a legitimate basis for regulating the setting for pregnancy terminations. Such is far from the case in the 1980's. All the medical practitioners performing pregnancy terminations subject to the hospital requirements at issue herein are licensed physicians.

Akron has failed to establish that non-hospital settings are inherently unsafe. A common pregnancy termination technique, dilatation and evacuation (D & E) is safely performed in out-patient

clinics through the 17th and 18th weeks of pregnancy, well into the second trimester. Since the Roe decision in 1973, specialized clinics for the performance of legal pregnancy terminations have had nearly 10 years to train and develop staff with expertise in these procedures.

In the modern factual setting, licensed physicians must be free to exercise their professional judgment in selecting appropriate settings for all medical procedures without legislative interference. To decide otherwise is to unwisely hold onto the shibboleths of the past. The City's hospitalization requirements merely reinforce the traditional sexual stereotype that women need special protection. These medical myths have led to gender-based classifications and legislative decisions which are

unconstitutional as well as unwise. This Court has recognized that in the areas of medicine and pregnancy termination rights, local governments must readjust their "views and emphases in the light of the advanced knowledge and techniques of the day." Doe v. Bolton, 410 U.S. 179, 190-191 (1973).

Akron has failed to demonstrate that pregnancy termination complications are not as safely treated by a licensed physician in a non-hospital medical facility as in a hospital. Serious complications during and after a pregnancy termination are rare and can occur in any setting, including a hospital. Mahoning Women's Center v. Hunter, 444 F.Supp. 12, 15 fn 7 (N.D. Ohio 1977). Akron has not met its burden of showing that a licensed physician exercises poor judgment by treating

those rare complications in a licensed clinic rather than in a hospital. Moreover, many doctors believe there is an increased risk of complications when pregnancy terminations are performed in hospitals instead of in out-patient clinics. Because of exposure to a larger patient population, some of whom are suffering from communicable diseases, there is an inherently greater risk of infection in a hospital than in a smaller clinic.

No similar prohibitions are imposed on licensed physicians attending home births, at which the risk to maternal health is as great as or greater than that borne by a woman undergoing an pregnancy termination at a well-equipped, licensed medical clinic. Similarly, there is no proscription against the

performance of amniocentesis by licensed physicians in clinics. If the risk to maternal health were in fact the real basis for the mandatory hospitalization requirement, the same requirement would logically be extended to childbirth and amniocentesis.

In reality, Akron cannot show that its hospital requirement is substantially related to the protection of maternal health.

Ironically, the mandatory hospitalization requirement, which many women cannot afford, may in fact be forcing women to return to back-alley, non-physician pregnancy terminations.

Akron has further failed to establish that a gender-neutral scheme is a less effective means of achieving its important governmental objective. Wengler v.

Druggist Mutual Insurance Co., supra, 446 U.S. 151, and Orr v. Orr, supra, 440 U.S. 282.

Akron has a gender-neutral mechanism for the protection of maternal health without the need for extraordinary prohibitions imposed upon doctors and patients. Akron licenses all physicians, and regulates and licenses all medical facilities, including clinics. Aggrieved and injured patients have access to the courts of Akron to file claims against physicians and clinics for negligence and other malpractice. All these protections exist without reference to gender. Therefore, the City's imposition of the hospitalization requirement attempt to protect interests in maternal health, already adequately protected. These extra layers of city intervention direct-

ly hamper the ability of doctors to practice medicine. See Word v. Poelker, 495 F.2d 1349, 1351 (8th Cir. 1974).

Akron has been unable to demonstrate that it requires physicians who perform minor surgery with risks equal to those of pregnancy termination to operate only in hospitals. "[T]hat the state is ordinarily willing to leave such matters to the professional judgment of the attending physician strongly suggests that the program for regulating abortion clinics is a thinly disguised effort to evade Roe and Doe." Friendship Medical Center, Ltd, v. Chicago Board of Health, 505 F.2d 1141, 1153 fn. 17 (7th Cir. 1974), cert. denied, 420 U.S. 997 (1975). This premise is even more imperative as applied to local governments.

Once this Court abandons the traditional notion that female patients require special legislative protection from licensed physicians who perform pregnancy terminations, there is no basis for finding a substantial relationship between the hospitalization requirement and the governmental objective. Cf. Mississippi University for Women v. Hogan, supra, at 5070 fn.11.

CONCLUSION

Under the guise of protections, legislatures have denied women access to professions, schools, and now adequate medical care. No man, even when his reproductive capacity is at stake in sterilization procedures, is subjected to nonmedical barriers to care. The government chooses not to interfere because it recognizes the necessity of speedy treatment and respects the doctor/patient relationship.

Not so with women. Here the City presumes to establish nonmedical preconditions for treatment. These conditions are unrelated to treatment. Each day a pregnancy termination is delayed because of parental consent, hospitalization, or any other legislative order, the risks to her life and health increase. Hence,

even if the City has a vested interest in maternal health, this interest is not served by delaying and complicating pregnancy terminations. Denying access to medical care to women but not to men through impermissible nonmedical barriers constitutes a denial of equal protection.

Respectfully submitted,

JUDITH A. HARPER
Women Lawyers of Sacramento
P.O. Box 161523
Sacramento, CA 95816

TAMARA DAHN
Placer County Women Lawyers
c/o Legal Services of
Northern California
199 Hoffman Avenue
Auburn, CA 95603

NANCI CLINCH
102 Colfax East
Grass Valley, CA 95945

MARGARET M. HALLORAN
Women Lawyers of Sacramento
1365 Oak Nob Way
Sacramento, CA 95833

ESTELLE SCHLEICHER
Women Lawyers of Sacramento
1005 Eighth Street, Ste 406
Sacramento, CA 95814

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IN THE

SUPREME COURT OF THE UNITED STATES

Nos. 81-746 and 81-1172

CITY OF AKRON,

Petitioners,

vs.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,

Cross-Petitioners,

vs.

CITY OF AKRON, et al.,

Cross-Respondents.

MOTION OF THE BOARD OF CHURCH AND SOCIETY OF THE UNITED METHODIST CHURCH, THE NATIONAL MINISTRIES OF THE AMERICAN BAPTIST CHURCHES IN THE U.S.A., THE UNITED PRESBYTERIAN CHURCH IN THE U.S.A., THE EPISCOPAL URBAN CAUCUS, AND THE AMERICAN FRIENDS SERVICE COMMITTEE FOR LEAVE TO JOIN THE BRIEF AMICUS CURIAE OF CERTAIN RELIGIOUS ORGANIZATIONS.

THE BOARD OF CHURCH AND SOCIETY OF THE UNITED METHODIST CHURCH, THE NATIONAL MINISTRIES OF THE AMERICAN BAPTIST CHURCHES IN THE U.S.A., THE UNITED PRESBYTERIAN CHURCH IN THE U.S.A., THE EPISCOPAL URBAN CAUCUS, AND THE AMERICAN FRIENDS SERVICE COMMITTEE hereby move this Court for leave to join the "Brief

Amicus Curiae Of Certain Religious Organizations"* previously filed in this case. The statements of interest of the five movant organizations are set forth hereinafter in Appendis A.

The facts relevant to this motion are the following:

1. On August 27, 1982, the Brief Amicus Curiae Of Certain Religious Organizations was served and filed in accordance with the rules of this Court.

2. At that time it was impossible for the movant religious organizations to join the brief because their formal process for approval could not be completed within the time constraints set by the Court.

3. Moreover, movants' participation as amici curiae is not simply cumulative. The position of the brief, that the staute is premised upon and advances belief in violation of the First Amendment generally and in violation of the Religion clauses specifically, is strengthened by the fact that it is adhered to by the majority of mainstream religious groups in this country. For example, the Board of Church and Society of the United Methodist Church, the National Ministries of the American Baptist Church in the U.S.A. and the United Presbyterian Church in the U.S.A. speak for or represent the views of denominations having a membership of 13.2 million people.

4. Movants are aware of the Court's reluctance to permit joinder of additional amici. However, here, because of the impossibility of timely decision and the relevance of demonstrating that the perspectives and arguments set forth in

* The participants in that brief were the following religious organizations: AMERICAN ETHICAL UNION; AMERICAN HUMANIST ASSOCIATION; CATHOLICS FOR A FREE CHOICE; COORDINATING CENTER FOR WOMEN IN CHURCH AND SOCIETY, UNITED CHURCH OF CHRIST; NATIONAL BOARD, YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF THE U.S.A.; NATIONAL COALITION OF AMERICAN NUNS; NATIONAL FEDERATION OF TEMPLE SISTERHOODS; NORTH AMERICAN FEDERATION OF TEMPLE YOUTH; OFFICE FOR CHURCH IN SOCIETY, UNITED CHURCH OF CHRIST; UNION OF AMERICAN HEBREW CONGREGATIONS; UNITARIAN UNIVERSALIST ASSOCIATION; UNITARIAN UNIVERSALIST WOMEN'S FEDERATION; UNITED CHURCH BOARD FOR HOMELAND MINISTRIES, UNITED CHURCH OF CHRIST; UNITED SYNAGOGUE OF AMERICA; WOMEN'S DIVISION, GENERAL BOARD OF GLOBAL MINISTRIES, UNITED METHODIST CHURCH; and WOMEN'S LEAGUE FOR CONSERVATIVE JUDAISM.

the amicus brief are indeed widely held in our society, movants suggest that this case is an exceptional one. See e.g., National Organization for Women v. Idaho, ___U.S.___, 102 S.Ct. 1272 (1982) (granting leave to Governor of Virginia to join brief filed on behalf of the Governor of Maine).

WHEREFORE, given the organizational impossibility of joining earlier and the significance of these organizations in the mainstream of religious groups today, movants respectfully request that the Court permit them to join the 16 organizations which signed the original brief.

Respectfully submitted,

Rhonda Copelon
c/o Center for Constitutional Rights
853 Broadway
New York, NY 10003
(212) 674-3303

Attorney for Amici Curiae.

Dated: New York, New York
October 9, 1982

APPENDIX A

AMERICAN BAPTIST CHURCHES, U.S.A.
(Annual Meeting, 1968)

Because Christ calls us to affirm the freedom of persons and sanctity of life, we recognize that abortion would be a matter of personal decision.

AMERICAN FRIENDS SERVICE COMMITTEE
(1980)

The American Friends Service Committee is the social justice arm of the Religious Society of Friends in America. It is active in relief and service work, reconciliation among nations and people, and programs to overcome discrimination and oppression. The AFSC has a vital interest in this litigation because of the Friends' belief in the infinite worth of each human being and the equality of all human beings in the sight of God which had led to the committment of a significant portion of its resources to work which seeks to root out the causes of violence in our society which lie in poverty and imbalance of wealth in the exclusion and denial of equal opportunity and rights on the basis of race and sex. It is aware that the decision to terminate a pregnancy is seldom easy and that the choice of sterilization is also a serious matter in light of its irreversibility. AFSC believes that in the end the individual must make the choice, free of coercion, including the coercion of poverty and services unavailable to those who cannot pay.

EPISCOPAL URBAN CAUCUS
(Position of Episcopal Church, General Convention, 1976)

Resolved: That the Episcopal Church express its unequivocal opposition to any legislation on the part of the national or state governments which would abridge or deny the right of individuals to reach informed decisions in this matter and to act upon them.

UNITED METHODIST CHURCH
(General Conference, 1976, 1980)

When an unacceptable pregnancy occurs, a family, and most of all the pregnant woman, is confronted with the need to make a difficult decision. We believe that continuance of a pregnancy which endangers the life or health of the mother, or poses other serious problems concerning the life, health, or mental capability of the child to be, is not a moral necessity. In such a case, we believe the path of mature Christian judgment may indicate the advisability of abortion. We support the legal right to abortion as established by the 1973 Supreme Court decisions. We encourage women in counsel with husbands, dotors, and pastors to make their own responsible decisions concerning the personal or moral questions surrounding the issue of abortion. (Resolution on Responsible Parenthood, 1976.)

Our belief in the sanctity of unborn human life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of the life and well-being of the mother, for whom devastating damage may result from an unacceptable pregnancy. In continuity with past Christian teaching, we recognize tragic conflicts of life with life that may justify abortion. (Social Principles, 1976, reaffirmed 1980.)

UNITED PRESBYTERIAN CHURCH IN THE U.S.A.
(General Assembly, 1972, reaffirmed 1978)

Whereas, God has given persons the responsibility of caring for creation as well as the ability to share in it, and has shown his concern for the quality and value of human life; and

Whereas, sometimes when the natural ability to create life and the moral and spiritual ability to sustain it are not in harmony, the decisions to be made must be understood as moral and ethical ones and not simply legal;

Therefore, in support of the concern for the value of human life and human wholeness...the 184th General Assembly:

b. Declares that women should have full freedom of personal

choice concerning the completion or termination of their pregnancies and that artificial or induced termination of pregnancy, therefore, should not be restricted by law, except that it be performed under the direction and control of a properly licensed physician.

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CERTIFICATE OF SERVICE

Rhonda Copelon, a member of the Bar of this Court and counsel for the Amici Curiae, certifies that she did cause this "Motion of the Board of Church and Society of the United Methodist Church, the National Ministries of the American Baptist Churches in the U.S.A., the United Presbyterian Church in the U.S.A., the Episcopal Urban Caucus, and the American Friends Service Committee for Leave to Join the Brief Amicus Curiae of Certain Religious Organizations" to be served upon the following counsel for the parties in this case:

Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44155

Robert D. Pritt
Department of Law
304 Municipal Building
Akron, Ohio 44308-1655

Alan G. Segedy
Segedy & Umbaugh
Law and Commerce Building
40 E. Mill Street (at Main)
Akron, Ohio 44308

Janet Benshoof
ACLU
132 W. 43rd Street
New York, New York 10036

by first class mail, postage prepaid.

Rhonda Copelon

Rhonda Copelon
c/o Center for Constitutional Rights
853 Broadway
New York, New York 10003
(212) 674-3303

Dated: New York, New York
October 9, 1982

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Nos. 81-746 and 81-1623

In The Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON, PETITIONER

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

JOHN ASHCROFT, ET AL., PETITIONERS

v.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

REX E. LEE
Solicitor General
J. PAUL MCGRATH
Assistant Attorney General
KENNETH S. GELLER
Deputy Solicitor General
RICHARD G. WILKINS
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

TABLE OF CONTENTS

	Page
Interest of the United States	1
Summary of argument	2
Argument:	
I. State regulations infringe upon a woman's right to privacy only if they unduly burden the abortion choice	4
II. In applying the "unduly burdensome" standard of review, federal courts should accord significant weight to the judgment of the state legislature	8
Conclusion	20

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Cases:

Abrams v. *United States*, 250 U.S. 616 13
Baldwin v. *Missouri*, 281 U.S. 586 19
Ball v. *James*, 451 U.S. 355 13
Bates v. *City of Little Rock*, 361 U.S. 516 8
Beal v. *Doe*, 432 U.S. 438 ..... 7, 18
Bellotti v. *Baird*, 428 U.S. 132 ..... 5–6, 18
Bellotti v. *Baird*, 443 U.S. 622 ..... 7, 9, 18
Carey v. *Population Services International*, 431 U.S. 678 8
Colautti v. *Franklin*, 439 U.S. 379 18
Fullilove v. *Klutznick*, 448 U.S. 448 10
Gibson v. *Florida Legislative Investigation Committee*, 372 U.S. 539 8
Griswold v. *Connecticut*, 481 U.S. 479 8
H.L. v. *Matheson*, 450 U.S. 398 ..... 6, 9, 11, 18
Harris v. *McRae*, 448 U.S. 297 ..... 2, 7, 18
Kramer v. *Union Free School District*, 395 U.S. 621 17
Lochner v. *New York*, 198 U.S. 45 11
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Marbury v. *Madison*, 5 U.S. (1 Cranch) 137 ..... 10–11, 16

Page

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Plyler v. *Doe*, No. 80–1538 (June 15, 1982) 15

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Whalen v. *Roe*, 429 U.S. 589 ..... 3, 14, 16

Williamson v. *Lee Optical*, 348 U.S. 483 17

Constitution and statutes:

United States Constitution, Fourteenth Amendment (Due Process Clause)..... 4

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42 U.S.C. 300a–6 1

Miscellaneous:

A. Bickel, *The Least Dangerous Branch* (1962) ... 16

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vol. 1..... 13

vol. 2..... 13

Page

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INTEREST OF THE UNITED STATES

These cases present the question whether two legislative bodies, in the course of resolving the competing interests at stake in the abortion decision, have unduly intruded upon a woman's right of privacy. While the United States has no particularized interest in addressing the merits of the actual legislative choices made by the State of Missouri and the City of Akron, it does have a substantial interest in preserving the proper sphere of legislative action. Congress has in the past enacted legislation impacting upon the abortion decision (see 42 U.S.C. 300a-6; Act of Nov. 20, 1979, Pub. L.

No. 96–123, Section 109, 93 Stat. 926), and may again do so in the future. The United States, therefore, has a significant interest in the outcome of the cases before the Court, because they will directly impact upon the ability of this country's elected representatives—both state and federal—to deal with an important issue of continuing public debate.

SUMMARY OF ARGUMENT

The Constitution does not forbid all state regulation of the abortion decision, either during the first trimester or thereafter. "[T]he right of personal privacy includes the abortion decision, but * * * this right is not unqualified and must be considered against important state interests in regulation." *Roe* v. *Wade*, 410 U.S. 113, 154 (1973). The court of appeals in *Akron Center for Reproductive Health, Inc.* v. *City of Akron* erred in concluding that any regulation having a "legally significant impact or consequence on a first trimester abortion decision * * * is invalid" (81–746 Pet. App. 10a). As this Court has made exceedingly clear, "*Roe* did not declare an unqualified 'constitutional right to an abortion[.]' * * * Rather, the right protects the woman from *unduly burdensome interference* with her freedom to decide whether to terminate her pregnancy." *Maher* v. *Roe*, 432 U.S. 464, 473–474 (1977) (emphasis added). See also 81–746 Pet. App. 25a–36a (Kennedy, J., dissenting). Abortion regulations invalidated by this Court have been found objectionable not merely because they constitute state regulation within a protected zone of privacy, but because they constitute "unduly burdensome interference" with the abortion choice. See, *e.g.*, *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 66–67, 81 (1976). Therefore, in furtherance of its important interest in protecting maternal health and potential life, a state may legitimately enact regulations relating to abortion so long as those regulations do not unduly burden the

woman's right under this Court's holding in *Roe* v. *Wade*, *supra*, to choose abortion rather than childbirth.

In applying the "unduly burdensome" standard of review to state regulation of the abortion decision, this Court should be especially sensitive to accord adequate weight to the legislative judgments involved. This Court aptly noted in *Roe* v. *Wade*, *supra*, that the "abortion controversy" has engendered "vigorous opposing views, even among physicians." 410 U.S. at 116. The abortion debate, involving questions of philosophy, medicine, religion, and oftentimes competing notions of morality, continues unabated. During the past ten years, that debate, which has resulted in numerous state enactments designed to accommodate the competing interests of those affected by the abortion decision, has centered principally in this Court. While the Court has an obligation to protect substantive constitutional rights from undue interference by the state, the Court "should not forget that 'legislatures are ultimate guardians of the liberties and welfare of the people in quite as great a degree as the courts.'" *Maher* v. *Roe*, *supra*, 432 U.S. at 479–480 (quoting *Missouri K. & T. Ry.* v. *May*, 194 U.S. 267, 270 (1904) (Holmes, J.)).

Whether or not a particular legislative enactment unduly burdens the abortion choice depends upon the resolution of competing public policy issues upon which reasonable people readily disagree. Because the legislature has superior fact-finding capabilities, is directly responsible to the public for its resolution of the policy issues it treats, and has greater flexibility than the courts to fine-tune and redirect its efforts if a particular solution is ill-founded or unwise, the courts should test the constitutionality of legislation impacting upon the abortion choice by an appropriately deferential standard. "State legislation which has some effect on individual liberty or privacy may not be held unconstitutional simply because a court finds it unnecessary, in whole or in part." *Whalen* v. *Roe*, 429 U.S. 589, 597 (1977).

ARGUMENT

I. STATE REGULATIONS INFRINGE UPON A WOMAN'S RIGHT TO PRIVACY ONLY IF THEY UNDULY BURDEN THE ABORTION CHOICE

In *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, the majority of the court of appeals concluded that all state regulation of the abortion decision is subject to a "two-step analysis" (81–746 Pet. App. 9a). First, a court will inquire whether a regulatory provision has a "'legally significant impact or consequence' on the right of a pregnant woman, in consultation with a physician, to choose to terminate her pregnancy" (*ibid.*). If a regulation has no such impact, "it does not raise a constitutional issue" (*ibid.*). If, however, the regulation does have such an impact, a court must take the second step and determine "whether or not the regulatory provision serves a legitimate and compelling state interest" (*ibid.*). Even a compelling state interest, however, is insufficient to save a regulation if "it imposes an 'undue burden' on the abortion decision" (*ibid.*). In the context of first trimester abortions, this analysis is fatal to virtually all state regulation. "Since the state has no compelling interest during the first trimester of pregnancy," any regulation resulting in "a legally significant impact or consequence on a first trimester abortion decision * * * is invalid" (*id.* at 10a). In our view, the court of appeals overstated the nature of the right of privacy protected by this Court's prior abortion cases and underestimated the state's legitimate ability to accommodate the competing interests of those affected by the abortion decision.

In *Roe* v. *Wade*, 410 U.S. 113, 153 (1973), the Court concluded that the "right of privacy" emanating from the Fourteenth Amendment's Due Process Clause "is broad enough to encompass a woman's decision whether

or not to terminate her pregnancy."[1] But while the Court recognized this privacy interest, it rejected the contention that "the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses" (*ibid.*). The privacy right involved in the abortion decision, the Court concluded, "cannot be said to be absolute" (*id.* at 154).

Notwithstanding the above, some language in *Roe* v. *Wade* suggests that, at least during the first trimester, a woman's decision in consultation with her physician to terminate her pregnancy is beyond the reach of any state regulation. See 410 U.S. at 163. The Court, however, has never applied *Roe* v. *Wade* in such a sweeping manner. See, *e.g.*, *Doe* v. *Bolton*, 410 U.S. 179, 208 (1973) (Burger, C.J., concurring) ("Plainly, the Court today rejects any claim that the Constitution requires abortions on demand"). Indeed, in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 66–67, 80–81 (1976), the Court upheld informed consent and recordkeeping requirements that undoubtedly impacted significantly upon first trimester abortion decisions.[2] In

[1] The cases now before the Court do not directly raise the question whether *Roe* v. *Wade*, *supra*, was correctly decided. The government, therefore, does not address that issue. The government's position in these cases, however, does not indicate agreement with *Roe* v. *Wade*.

[2] For example, the consent provision in *Danforth* required a woman to "certify in writing her consent to the procedure and *'that her consent is informed* and freely given and is not the result of coercion'" (428 U.S. at 65) (emphasis added). Despite the seemingly absolute language in *Roe* v. *Wade*, *supra*, the Court did not hold that this requirement for informed, written consent to first trimester abortions unduly intruded upon a woman's right of privacy. "The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences" (428 U.S. at 67). *Danforth*, in short, noted the strength of the state interest furthered by the informed consent regulation, weighed it against its intrusion upon a woman's unfettered dis-

Bellotti v. *Baird*, 428 U.S. 132, 147 (1976) (*Bellotti I*), handed down the same day as *Danforth*, the Court explained that such state regulation of first trimester abortions "is not unconstitutional unless it unduly burdens the right to seek an abortion." Thus, the primary inquiry is not, as the court of appeals in *Akron Center* suggested, whether a particular regulation has a "significant impact" upon the abortion decision (as informed consent and recordkeeping requirements undoubtedly have), but rather whether or not a regulation "unduly burdens" the abortion choice. In making this determination, the Court must balance the state interests furthered by the regulation against the woman's privacy interest. As noted in *Roe* v. *Wade* itself, "the right of personal privacy includes the abortion decision, but * * * this right is not unqualified and must be considered against important state interests in regulation" (410 U.S. at 154).[3]

This Court has repeatedly adopted an "unduly burdensome" analysis in the context of reviewing legislative enactments impacting upon the abortion decision.

---

cretion, and concluded that it did not unduly burden the abortion decision. See *Bellotti* v. *Baird*, 428 U.S. 132, 147 (1976) (*Bellotti I*).

[3] The Court has recognized that the state has at least two "important and legitimate" interests at stake in every abortion decision: the interest "in preserving and protecting the health of the pregnant woman," and the interest "in protecting the potentiality of human life" (410 U.S. at 162). The variables involved in the abortion decision, however, are plainly not limited to maternal health and protection of potential life. Beyond these two well-established concerns, the state has a legitimate interest in safeguarding the rights of other parties affected by the abortion decision, such as the familial prerogatives of the parents of minor girls (*H.L.* v. *Matheson*, 450 U.S. 398, 407–410 (1981); *Bellotti* v. *Baird*, 443 U.S. 622, 633–639 (1979) (*Bellotti II*) (opinion of Powell, J.)), and the "deep and proper concern" of a father for his child (*Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 69, 71–72).

Harris v. *McRae*, 448 U.S. 297, 314 (1980); *Maher* v. *Roe*, 432 U.S. 464, 473–474 (1977); *Beal* v. *Doe*, 432 U.S. 438, 446 (1977). As the Court stated in *Maher*, "the right in *Roe* v. *Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it. *Roe* did not declare an unqualified 'constitutional right to an abortion,' as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." 432 U.S. at 473–474. See also *Bellotti* v. *Baird*, 443 U.S. 622, 640 (1979) (*Bellotti* II) (opinion of Powell, J.) (the question before the Court is whether a Massachusetts statute "provides for parental notice and consent in a manner that does not unduly burden the right to seek an abortion"). Abortion regulations invalidated by the Court have never been found objectionable merely because they impact upon some unusually discrete zone of privacy, but rather because they result in an unduly burdensome interference with the abortion choice. See, *e.g.*, *Harris* v. *McRae*, *supra*, 448 U.S. at 328 (White, J., concurring) (*Roe* v. *Wade* operates to free a woman from "unreasonable official interference with private choice"). One simply cannot view "the zone of privacy as a legal island of personal autonomy in the midst of a sea of public regulation and interaction," because the metaphor fails at a most critical juncture—it does not illuminate what constitutes an impermissible "coming ashore." Gerety, *Redefining Privacy*, 12 Harv. C.R.-C.L. L. Rev. 233, 271 (1977). See also Wood & Durham, *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U. L. Rev. 783, 803–804. The "unduly bur-

densome" standard of review provides this vital benchmark.[4]

Selection of the proper standard is vital to appropriate review of state regulations impacting upon the abortion decision. Selecting a standard of review, however, is only the beginning. It is the application of that standard that necessarily and unavoidably raises delicate issues of serious constitutional concern.

II. In Applying the "Unduly Burdensome" Standard of Review, Federal Courts Should Accord Significant Weight to the Judgment of the State Legislature

A. Abortion is an issue that has been and will continue to be the focus of great national debate. The subissues in the debate are numerous and complex, including such questions as the relative safety of medical procedures, how much information a woman should have before she makes an abortion decision, and the ex-

[4] The "unduly burdensome" standard of review, moreover, is consistent with the approach the Court has taken in other cases involving "fundamental rights." In *Carey* v. *Population Services International*, 431 U.S. 678 (1977), for example, the Court invalidated a New York statute regulating the sale and distribution of nonprescription contraceptives. The Court concluded that the statute in question, which proscribed the sale or distribution of contraceptives by other than registered pharmacists and prohibited their distribution to minors, imposed "a *significant burden* on the right of the individuals to use contraceptives" (431 U.S. at 689; emphasis added). See also *id.* at 688; *id.* at 705 (Powell, J., concurring). This language is consistent with the analysis in *Maher* and other cases discussed above. The "question of invasion of privacy is inescapably a question of degree—a question of 'unduly burdensome interference.'" Wood & Durham, *supra*, 1978 B.Y.U. L. Rev. at 805 n.104. Other "fundamental rights" cases are in accord. See, *e.g.*, *Griswold* v. *Connecticut*, 381 U.S. 479, 485 (1965) ("maximum destructive impact"); *Gibson* v. *Florida Legislative Investigation Committee*, 372 U.S. 539, 545 (1963) ("infringe substantially"); *Bates* v. *City of Little Rock*, 361 U.S. 516, 524 (1960) ("significant encroachment"); *Pierce* v. *Society of Sisters*, 268 U.S. 510, 534–535 (1925) ("unreasonably interferes").

~~9 have before she makes an abortion decision, and the ex-~~ tent to which a spouse or the parents of a minor or immature pregnant child should be entitled to notice or consent. See, *e.g.*, *H.L.* v. *Matheson*, *supra*, 450 U.S. at 407–410; *Bellotti* v. *Baird*, *supra*, 443 U.S. at 633–639; *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 67–79.

Competing views on these and related issues are deeply held by large numbers of American citizens. Pro-life and pro-choice advocates, for example, are not likely to agree on the amount of involvement to which the parents of a minor child should be entitled with regard to that child's decision to have an abortion. Since the two sides will never agree, some governmental entity must make a choice between the two competing positions. In our democratic society the governmental body with the primary authority and responsibility to resolve competing policy views and pressures among citizens is the legislature. In the abortion context, as in many others, legislation consists of selecting one set of competing private interests over another.

In the cases currently before the Court, as well as in the case of many other abortion statutes in this country, the legislatures have done their job. Some legislatures settle upon one solution or combination of solutions, while in other states the process yields different results. But in each instance the representatives of the people—who must answer to the people for what they do—have considered the people's competing viewpoints and have made the difficult choices required by the legislative process.[5] From state to state, and from issue to issue, some have won and some have lost. Pro-choice advocates have persuaded some legislatures on parental

[5] To the extent constitutional values were implicated, those values were taken into account because legislators, like other public servants, take an oath to uphold the Constitution. *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981).

notification issues but not on hospitalization; pro-life proponents have won the informed consent debate in one state and lost it in another.

These cases call for a determination of the standard that will govern abortion issues not yet resolved by the Court. For reasons stated in Part I, under this Court's precedents the "compelling state interest" test does not apply automatically to all regulations bearing on the abortion decision. Rather, that test applies only to state regulations that unduly burden the abortion decision. Whether or not a particular regulation "unduly burdens" the abortion decision, however, is far from self-evident. In light of the breadth and the ambiguity of the "unduly burdensome" standard—and in the interest of preserving the difference between what courts do and what legislatures do—this Court should clarify that in applying that standard on a case-to-case basis courts should be mindful that (1) at their root, the issues to which the "unduly burdensome" test is applied are policy issues, and different segments of our society have strong competing views concerning them; (2) the legislature has already considered the competing arguments, made the necessary factual inquiries, and reached a decision; and (3) the net effect of holding the legislative product unconstitutional is that those who succeeded in persuading the legislature of the soundness of their policy viewpoint are deprived of their legislative victory, whereas the legislative losers become the winners. These realities counsel that, in deciding which legislative policy choices are "unduly burdensome" and which are not, the Court should accord heavy deference to the legislative judgment. See *Fullilove* v. *Klutznick*, 448 U.S. 448, 472 (1980).

B. The ultimate determination of constitutionality rests, of course, with the courts, and judicial review is as basic to judicial authority as policy choices are to legislative authority. *Marbury* v. *Madison*, 5 U.S. (1

Cranch) 137 (1803). Each is equally important to separation of powers. The dividing line between constitutional interpretation and choosing among competing policy alternatives, however, is not always fine or bright. Compare *Lochner* v. *New York*, 198 U.S. 45 (1905), with *West Coast Hotel Co.* v. *Parrish*, 300 U.S. 379 (1937). The issues in this case are illustrative. On the one hand, parental entitlement to notification of or participation in an immature daughter's decision that could profoundly affect her life presents competing considerations whose resolution lie at the very core of what legislators are elected to do. See *H.L.* v. *Matheson*, *supra*, 450 U.S. at 408–410. On the other hand, courts may conclude that the legislative judgment impermissibly impedes the exercise of a constitutional right. See *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 72–75. In such cases—where the resolution of competing interests may be regarded as falling within the domain of either the legislature or the courts— which branch is entitled to deference from the other? Alternatively stated, which branch should be primary in those areas that might belong to either by application of traditional assumptions concerning the allocation of governmental authority? The legislature makes law when it chooses between competing policy alternatives. The court makes law when it declares constitutional principles. Which should enjoy residual lawmaking authority? In cases of overlap between the two, should the tilt be toward the legislature who makes law by selecting among policy choices, or toward the judge who makes law by interpreting the Constitution?[6]

[6] The issue is one that rests at the very foundation of a system of government grounded in separation of powers. It cannot be disposed of by facile generalizations such as, "legislatures cannot repeal a constitutional right" or "courts should not sit as super legislatures." The reality is that some issues fall within the purview of both legislative primacy because they involve policy choice and also judicial authority to decide constitutional-

The answer, we submit, rests on consideration of three basic differences between the legislative and judicial branches and the way those branches function. First, the legislator has superior fact-finding capability. He or she is not limited either by the case or controversy requirement, or by the decision of legal counsel in a particular case to construct the record in a particular way. The legislator is not only free to inquire into any relevant facts, but can carry that inquiry wherever the general public interest, rather than the interests of private litigants, might indicate. The second difference is that legislators must periodically account to the people for the way they have carried out their public responsibilities. By definition, issues that fall within the area of possible overlap between legislative and judicial authority involve public policy choices. They are issues that affect people. They are issues on which peoples' views may differ mightily. Vesting this residual lawmaking authority in the legislature rather than the judiciary renders the government accountable for the exercise of that authority.[7]

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ity. The issue is not one of preclusion, because neither branch should be able completely to foreclose the other in an area of overlapping authority. Rather, the issue is one of deference. Which branch should have a presumed preference in lawmaking authority in those areas that might properly belong to either? See, *e.g.*, Ely, *The Wages of Crying Wolf: A Comment on Roe* v. *Wade*, 82 Yale L.J. 920, 935 n.89 (1973) ("precisely because the claims involved [in the abortion dispute] are difficult to evaluate, I would not want to entrust to the judiciary authority to guess about them—certainly not under the guise of enforcing the Constitution").

[7] As Justice Powell warned in his concurring opinion in *United States* v. *Richardson*, 418 U.S. 166, 188 (1974), vesting the courts with broad authority to second-guess legislative judgments is inherently anti-democratic:

> We should be ever mindful of the contradictions that would arise if a democracy were to permit general oversight of the elected branches of government by a nonrepresentative, and in large measure insulated, judicial branch.

Third, regardless of which governmental body is vested with residual lawmaking authority, the quality of the lawmaking product is enhanced by leaving the issues exposed for a time to the legislative process and the public pressures that are brought to bear on that process.[8] See, *e.g.*, *Ball* v. *James*, 451 U.S. 355, 373 (1981) (Powell, J., concurring). One of the fundamental postulates undergirding a free and open democratic society is that the search for truth is enhanced by permitting a full and uninhibited discussion of public issues. *Abrams* v. *United States*, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting). Necessarily, such a discussion is more effective if the ultimate resolution of the issue has not been removed from the realm of public debate and resolution through constitutional determination. The issues in this case, as well as other abortion disputes not yet resolved by the Court, are subject to differing views that are widely and fervently held. See, *e.g.*, *Roe* v. *Wade*, *supra*, 410 U.S. at 116 (noting "vigorous opposing views, even among physicians"). The

[8] The Founding Fathers emphatically rejected the suggestion that the federal judiciary serve as a "Council of Revision" to pass upon the wisdom of "every act of the National Legislature before it shall operate * * *." 1 M. Farrand, *The Records of the Federal Convention of 1787*, at 21 (1911). Nathaniel Gorham of Massachusetts argued that he "did not see the advantage of employing the Judges in this way. As Judges they are not to be presumed to possess any peculiar knowledge of the mere policy of public measures." 2 M. Farrand, *supra*, at 73. It was also argued to be "necessary that the Supreme Judiciary should have the confidence of the people" and this confidence would "soon be lost, if [judges] are employed in the task of remonstrating agst. popular measures of the Legislature." *Id.* at 76–77. Elbridge Gerry of Massachusetts asserted that "[h]e relied for his part on the Representatives of the people as the guardians of their Rights and interests." *Id.* at 75. This sentiment was echoed almost a century and three-quarters later by Judge Learned Hand: "For myself it would be most irksome to be ruled by a bevy of Platonic Guardians, even if I knew how to choose them, which I assuredly do not." L. Hand, *The Bill of Rights* 70 (1958).

best way to determine who is right and who is wrong on those issues is to permit and encourage the opposing sides to exercise their persuasive efforts on state legislators.[9] Equally beneficial to the search for the optimal solution is the likelihood that on any given issue, different legislatures will reach different results, and the ensuing practical experiences in the various states will cast further light on the underlying issues. This is the process by which a free, elected government works best.[10] To whatever extent the issues are constitu-

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[9] There are profound divisions of opinion among physicians, religious leaders, theologians, philosophers, state and federal elected representatives, and individual citizens with respect to the issue of abortion generally as well as the subissues specifically raised in the cases presently before this Court. Differences among experts are no less profound in this area than in the area of education, in which the Court has eschewed second-guessing legislative judgments. This Court's observations in *San Antonio School District* v. *Rodriguez*, 411 U.S. 1, 42–43 (1973), are as applicable to legislative determinations concerning abortion as to legislative decisions concerning education:

> On even the most basic questions [in the area of education] the scholars and educational experts are divided. * * * The ultimate wisdom as to these [issues] is not likely to be divined for all time even by the scholars who now so earnestly debate [them]. In such circumstances, the judiciary is well advised to refrain from imposing on the States inflexible constitutional restraints that could circumscribe or handicap the continued research and experimentation so vital to finding even partial solutions to educational problems and to keeping abreast of ever-changing conditions.

[10] In *Walen* v. *Roe*, *supra*, 429 U.S. at 597, the Court emphasized that individual states must "have broad latitude in experimenting with possible solutions to problems of vital local concern." The Court stated that "Mr. Justice Brandeis' classic statement of the proposition merits reiteration" (*id.* at n.20) (quoting *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting):

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experi-

tionalized, they are thereby removed from this refining process—the process by which lawmakers learn through experimentation and correction. Constitutionalization eliminates all but one of the competing points of view as acceptable alternatives; the issue is removed from the realm of public debate and decisionmaking.[11]

This is not to say that courts must always yield to legislatures in areas of overlap between the power of each. Rather, the point is that in those cases where the issue might be fairly characterized as involving either a choice among competing policy alternatives, or a pronouncement of constitutional principle, the presumption should favor treating the issue as one of policy choice.[12]

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ments without risk to the rest of the country. This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious or unreasonable. We have power to do this, because the due process clause has been held by the Court applicable to matters of substantive law as well as to matters of procedure. But in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles.

[11] Moreover, to the extent the judiciary presumes to provide solutions to inherently legislative problems, it may weaken the resolve of the legislative branch to assume political accountability for those problems. James Bradley Thayer described this consequence of the exercise of judicial review in his biography of John Marshall:

> [T]he exercise of [the judiciary's power of review], even when unavoidable, is always attended with a serious evil, namely, that the correction of legislative mistakes comes from the outside, and the people thus lose the political experience, and the moral education and stimulus that come from fighting the question out in the ordinary way, and correcting their own errors * * *. The tendency of a common and easy resort to this great function, now lamentably too common, is to dwarf the political capacity of the people, and to deaden its sense of moral responsibility.

J.B. Thayer, *John Marshall* 106–107 (1901). See *Plyler* v. *Doe*, No. 80–1538 (June 15, 1982), slip op. 13–14 (Burger, C.J. dissenting).

[12] In addition to the differences, discussed above, between courts and legislatures, judicial deference to the legislature is

C. The fact that this Court has declared that the abortion decision is a fundamental right does not, in itself, justify far-ranging judicial preemption of state or federal legislation impacting upon that decision. The reasons are two. First, under any circumstances, assigning comparative weights to individual interests adversely affected by governmental action is a task that does not readily lend itself to judicial resolution. See A. Bickel, *The Least Dangerous Branch* 15 (1962). It is not that some interests are not more weighty or "fundamental" than others. Of course they are. But if a governmental determination of comparative importance is to be made, who is in the better position to decide what is in first place, what is in second and third place, and how much distance there is between each category?

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also supported by a consideration fundamental to separation of powers theory. Either branch could legitimately lay claim to primacy in the area of overlap, since the issues in this area involve policy choices as well as the meaning of the Constitution. The final arbiter, however, of which branch is to prevail is necessarily the judiciary. *Marbury* v. *Madison*, *supra*. Where one of the branches is not only a territorial claimant but also the final judge of the territorial dispute, that branch should conscientiously lean away from its own claim in otherwise close cases. See *Whalen* v. *Roe*, *supra*, 429 U.S. at 597. See also Hazard, *The Supreme Court as a Legislature*, 64 Cornell L. Rev. 1, 16–17 (1978). As the Court recognized in *Valley Forge Christian College* v. *Americans United for Separation of Church and State, Inc.*, No. 80–327 (Jan. 12, 1982), slip op. 8–9, a restrained exercise of the ultimate judicial power of declaring a legislative act unconstitutional is essential to the continued effectiveness of that power:

> The exercise of the judicial power also affects relationships between the coequal arms of the national government. The effect is, of course, most vivid when a federal court declares unconstitutional an act of the Legislative or Executive branch. While the exercise of that "ultimate and supreme function," *Chicago & Grand Trunk R. Co.* v. *Wellman*, 143 U.S. [339,] 345 [(1892)], is a formidable means of vindicating individual rights, when employed unwisely or unnecessarily it is also the ultimate threat to the continued effectiveness of the federal courts in performing that role.

The "comparative fundamentality" of any interest is a function of the interests of individual persons. Those persons, moreover, are the best judges of what interests ought to be accorded greater weight by government, regardless of the theory by which the weights are assigned or the labels attached. Those persons are also the people who elect legislators. Therefore, the fine-tuning that is necessarily involved in determining which interests should be more or less weighty and what the differences should be is appropriately left to the elected branches.[13] See H. Black, *A Constitutional Faith* 11 (1968).

Second, whatever the problems generally attendant upon judicial determination of fundamental rights, the extension of that approach to these cases is particularly inappropriate. Ten years ago this Court declared a three-part set of rules prescribing what is permissible and what is impermissible, depending on the stage of pregnancy at which the abortion occurs. Many questions were left unanswered, and over the intervening decade, adversaries have periodically returned to ask

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[13] Consider, for example, the individual interests in two leading cases at opposite ends of the spectrum of this Court's deference to state legislative judgment, *Kramer* v. *Union Free School District*, 395 U.S. 621 (1969), and *Williamson* v. *Lee Optical*, 348 U.S. 483 (1955). *Kramer* held that New York may not constitutionally limit the right to vote in school board elections to parents of school-age children or owners or renters of real property. The reason: the right to vote is fundamental. *Williamson*, by contrast, held that Oklahoma has very broad discretion to determine who may engage in the business of fitting eyeglass lenses into frames. Assume that New York adopted the same regulatory statute involved in *Williamson*, and assume further that Morris Kramer was an optician rather than a stockbroker. Which would he say was more "fundamental" to him—the right to practice his business or the right to vote for school board members so long as he had no school-age children and bore none of the schools' financial burdens?

the Court to fill in more detail, resulting in a set of rules that has become increasingly intricate and substantially more complicated. See, *e.g.*, *H.L.* v. *Matheson*, *supra*; *Harris* v. *McRae*, *supra*; *Bellotti* v. *Baird* (*Bellotti II*), *supra*; *Colautti* v. *Franklin*, 439 U.S. 379 (1979); *Maher* v. *Roe*, *supra*; *Beal* v. *Doe*, *supra*; *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*; *Bellotti* v. *Baird* (*Bellotti I*), *supra*.

In the instant cases, the competing sides in the abortion controversy are back again. Unless the Court clarifies that in applying the "undue burden" test to all future issues substantial deference is to be accorded the legislative judgment, these cases will result in more detail and more complexity, taking the Court further away from what courts do best and more into the realm of what legislatures do best.[14] Even more important,

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[14] In recent years, this Court has been called upon to engage in increasingly difficult line-drawing involving such questions as parental and spousal consent or notification (*Bellotti* v. *Baird*, *supra*, 428 U.S. at 145; *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 67–75; *Bellotti* v. *Baird*, *supra*, 443 U.S. at 639–651, 652–656; *H.L.* v. *Matheson*, *supra*, 450 U.S. at 407–413), the relative merits and demerits of such discrete medical techniques as saline amniocentesis (*Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 75–79), the determination of viability (*Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 64; *Colautti* v. *Franklin*, *supra*, 439 U.S. at 390–394), and public funding of the abortion decision (*Beal* v. *Doe*, *supra*; 432 U.S. *Maher* v. *Roe*, *supra*; *Harris* v. *McRae*, *supra*). These and similar issues are well-suited to legislative resolution. For example, the two cases currently before the Court raise the issue whether a state may legitimately require that all second trimester abortions take place in a hospital rather than an abortion clinic. The court of appeals in No. 81–1623 rather candidly admitted that in resolving this question "it is clear that the central issue is the relative safety of nonhospitalized * * * and hospitalized [abortion techniques]" (81–1623 Pet. App. A–64). This and other remaining abortion issues (such as informed consent requirements, physician-patient counseling, and the age at which daughters may proceed without their parents being notified) are

over the ensuing decades, the adversaries will be back again and again. Each time, the set of rules will inevitably become longer and more detailed. See, *e.g.*, *Planned Parenthood of Central Missouri* v. *Danforth*, *supra*, 428 U.S. at 92 (White, J., dissenting) ("[t]he task of policing this limitation on state police power is and will be a difficult and continuing venture in substantive due process"). Very simply, that is an unfair and improper burden to impose upon any Constitution. It is especially unfair to impose it on a Constitution that contains no mention of the words "privacy" or "abortion" and that can be extended to those matters only by piecing together a combination of shadows from a variety of explicit guarantees contained in the document.[15] Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, *supra*, 82 Yale L.J. at 937–949.

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the kinds of issues best resolved by legislatures, with their superior fact-finding capabilities and their ability to redirect and fine-tune their efforts in light of evolving medical knowledge and other changed circumstances. As Justice Powell noted in his concurring opinion in *United States* v. *Richardson*, 418 U.S. 166, 188 (1974):

> repeated and essentially head-on confrontations between the life-tenured branch and the representative branches of government will not, in the long run, be beneficial to either. The public confidence essential to the former and the vitality critical to the latter may well erode if we do not exercise self-restraint in the utilization of our power to negate the actions of the other branches.

[15] *Baldwin* v. *Missouri*, 281 U.S. 586, 595 (1930) (Holmes, J., dissenting):

> [W]e ought to remember the great caution shown by the Constitution in limiting the power of the States, and should be slow to construe the clause in the Fourteenth Amendment as committing to the Court, with no guide but the Court's own discretion, the validity of whatever laws the States may pass.

The time has come to call a halt to that process. The Court should declare that the governing standard is whether the state regulation at issue unduly burdens the abortion decision, and that in deciding on a case to case basis whether the burden is permissible or impermissible, courts should give heavy deference to the state legislative judgment. In the cases before the Court, the effect of that holding will be to vacate the judgments of the court of appeals to the extent they fail to uphold the constitutionality of what the Missouri legislature and the Akron City Council have done, and to remand the cases for further consideration under a more deferential standard. In the future, the effect will be to channel further refinements of abortion law largely into the stream of state legislative authority.

CONCLUSION

The portions of the court of appeals' judgments that invalidate segments of petitioners' abortion regulations should be vacated and the cases remanded for reconsideration in light of the standard proposed in this brief.

Respectfully submitted.

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

KENNETH S. GELLER
Deputy Solicitor General

RICHARD G. WILKINS
Assistant to the Solicitor General

JULY 1982

NO. 81-746-CFX (Vide: 81-854) 81-1172	TITLE	City of Akron, Petitioner v. Akron Center for Reproductive Health, Inc., et al.

DOCKETED	COURT
Oct. 13, 1981	United States Court of Appeals for the Sixth Circuit

DATE	PROCEEDINGS AND ORDERS
	Counsel for Petitioner: Robert D. Pritt
	Counsel for Respondents: Robert A. Destro, Stephan Landsman
Oct. 13, 1981	Petition for writ of certiorari filed. (Record filed)
Nov. 19, 1981	Order extending time to file a response to the petition until Dec. 9, 1981, for ALL RESPONDENTS filed.
Dec. 7, 1981	Waiver of right to file a response to the petition by respondents Francois Seguin, M.D. and Patricia Black filed.
Dec. 10, 1981	Consolidated brief for the respondents in opposition filed. (Vide: 81-854)
Dec. 16, 1981	DISTRIBUTED. 1-8. (Stricken)
Jan. 20, 1982	DISTRIBUTED. 2-19.
Mar. 31, 1982	REDISTRIBUTED. 4-16.
Apr. 20, 1982	REDISTRIBUTED. 4-23. (Stricken)
Apr. 27, 1982	REDISTRIBUTED. 4-30. (Stricken)
May 10, 1982	REDISTRIBUTED. 5-13.
May 17, 1982	REDISTRIBUTED. 5-20.
May 24, 1982	Petition GRANTED. The case is consolidated with 81-1172 and a total of one hour is allotted for oral argument.

June 8, 1982	The City of Akron will file its opening brief on July 8, 1982. Akron Center for Reproductive Health, et al. will file their opening brief on Aug. 7, 1982. DEFERRED APPENDIX METHOD
June 19, 1982	Brief, amicus curiae, by the Legal Defense Fund for Unborn Children filed. (Vide: 81-1172).
June 19, 1982	Motion of Alan Ernest to represent children unborn and born alive filed. (Vide: 81-1172).
June 28, 1982	The motion of Alan Ernest to represent children unborn and born alive is DENIED.
July 2, 1982	The City of Akron will file its opening brief on or before July 29, 1982.
July 2, 1982	Akron Center for Reproductive Health, et al. will file their opening brief on or before Aug. 28, 1982.
July 20, 1982	Brief, amici curiae, of United Families Foundation and Women Exploited filed.

(Over)

81-746

Title

No.

DATE	PROCEEDINGS AND ORDERS
July 26, 1982	Brief, amicus curiae, for Lawyers for Life filed. (Vide: 81-1172).
July 19, 1982	Application of respondent and cross petitioner Akron Center for Reproductive Health, Inc., et al. for leave to file its brief on the merits in excess of page limitations, and order denying same by O'Connor, J., 7/26/82.
July 29, 1982	Brief for the U. S. as amicus curiae in support of petitioners filed. (Also in 81-1623)
July 29, 1982	Brief for petitioner City of Akron filed. (Vide: 81-1172)
Aug. 2, 1982	Brief, amicus curiae, of Americans United for Life in support of petitioner filed.
Aug. 2, 1982	Brief, amicus curiae, of Womankind, Inc., in support of petitioner filed.
Aug. 2, 1982	Brief, amicus curiae, of Feminists for Life in support of petitioner filed.
Aug. 4, 1982	Brief, amicus curiae, of The Catholic League for Religious and Civil Rights filed. (Vide: 81-1172).
Aug. 4, 1982	Brief amici curiae of Certain Law Professors filed. (Vide: 81-1172).
Aug. 4, 1982	Brief, amici curiae, and Annexed Brief of the Committee for Abortion Rights and Against Sterilization Abuse, et al. filed. (Vide: 81-1172).
Aug. 4, 1982	Brief, amici curiae, on Behalf of National Organization for Women, et al. filed. (Vide: 81-1172).
Aug. 5, 1982	Application by Planned Parenthood Federation of American, Inc. for leave to file a brief as amici curiae in excess of page limitations filed, and order denying same by Burger, CJ., 8/6/82.
Aug. 11, 1982	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Aug. 7, 1982	Motion of the American Public Health Association for leave to file a brief as amicus curiae filed. (Vide: 81-1172).
Aug. 17, 1982	Motion of Francois Sequin, M.D., et al. for divided argument and for additional time for oral argument filed.
Aug. 18, 1982	Opposition of Akron Center for Reproductive Health, Inc., et al. filed. (Vide: 81-1172)
Aug. 26, 1982	Brief, amicus curiae, of the College of American Pathologists in support of respondent filed.
Aug. 27, 1982	Brief, amicus curiae, of the American College of Obstetricians and Gynecologists, et al. filed. (Vide: 81-1172)
Aug. 27, 1982	Brief, amicus curiae, of American Psychological Association in support of respondents filed.

(Card No. 2)

NO. 81-746-CFX	TITLE City of Akron, Petitioner, v. Akron Center for Reproductive Health, Inc., et al.

DOCKETED	COURT
Oct. 13, 1982	United States Court of Appeals for the Sixth Circuit

DATE	PROCEEDINGS AND ORDERS
Aug. 27, 1982	Brief, amici curiae, of Women Lawyers of Sacramento, et al. filed. (Vide: 81-1172).
Aug. 28, 1982	Brief, amici curiae, of Planned Parenthood Federation of America, Inc., et al. filed. (Vide: 81-1172).
Aug. 30, 1982	Brief, amicus curiae, for the NAACP Legal Defense and Educational Fund, Inc. filed. (Vide: 81-1172).
Aug. 30, 1982	Brief, amicus curiae, of Certain Religious Organizations filed. (Vide: 81-1172).
Aug. 30, 1982	Brief, amicus curiae, of The National Abortion Federation filed. (Vide: 81-1172).
Aug. 31, 1982	Brief, amici curiae, of California Women Lawyers, et al. filed. (Vide: 81-1172).
Sept. 20, 1982	Motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae filed.
Sept. 13, 1982	Joint appendix filed. (Vide: 81-1172).
Sept. 22, 1982	Brief for respondents filed. (Vide: 81-1172)
Sept. 29, 1982	Reply brief for Petitioner, City of Akron, filed. (Vide: 81-1172 - Respondents).
Oct. 4, 1982	The motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument is GRANTED. The motion of Francois Seguin, M.D. et al. for divided argument and for additional time for oral argument is DENIED. The motion of The Legal Defense Fund for Unborn Children for leave to participate in oral argument as amicus curiae is DENIED.
Oct. 4, 1982	Brief of respondents Francois Seguin, M.D. and Patricia K. Black filed. (Vide: 81-1172).
Oct. 12, 1982	Motion of The Board of Church and Society of the United Methodist Church, et al. for leave to join amicus curiae brief of Certain Religious Organizations filed. (Also in 81-1172).
Oct. 18, 1982	The motion of The Board of Church and Society of the United Methodist Church, et al. for leave to join the brief, amicus curiae, of Certain Religious Organizations is denied.
Nov. 23, 1982	Reply brief of petitioner City of Akron filed. (D) (Vide: 81-1172).
Nov. 23, 1982	Reply brief for respondents and cross-petitioners filed. (D) (Vide: 81-1172).

(Over)

81-746

Title

No.

DATE	PROCEEDINGS AND ORDERS
Nov. 30, 1982	ARGUED.